

North Dakota Developmental Disabilities Human Rights Committee (HRC) & Behavior Support Committee (BSC) Provider Toolkit

Regulations and standards:

State statutes pertinent to seclusion and/or restraint include NDCC 25-01.2-01 (3), NDCC 25-01.2-02, NDCC 25-01.2-08, NDCC 25-01.2-09, and NDCC 25-01.2-10 in chapter NDCC 25- 01.2 on Developmental Disabilities and NDCC 25-01.3-01 (1) and (14), which pertains to definitions of abuse and neglect in chapter NDCC 25-01.3 of the Committee on Protection & Advocacy.

Federal statutes include 42 U.S.C. § 15009 entitled Rights of Individuals with Developmental Disabilities and 42 U.S.C. § 290jj entitled Requirements Relating to the Rights of Residents of Certain Non-medical, Community-based Facilities for Children and Youth. Federal regulations include 42 C.F.R. 483.420 entitled Condition of participation: Client protections, 42 C.F.R. 483.440 entitled Condition of participation: Active treatment services, 42 C.F.R. § 483.450 entitled Condition of participation: Client behavior and facility practices, 45 C.F.R. § 1386.19 – entitled State System for Protection and Advocacy of the Rights of Individuals with Developmental Disabilities.

Policies adopted and promulgated by the ND DHS/DDD can be found on the DHS website: ND DHS bookshelf at <http://www.nd.gov/dhs/policymanuals/816/816.htm>

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3/10/2021



TABLE OF CONTENTS

PURPOSE OF THIS DOCUMENT	5
VALUES AND PHILOSOPHY	5
HUMAN RIGHTS COMMITTEE.....	6
PURPOSE & PROCESS GUIDELINES OF A HUMAN RIGHTS COMMITTEE (HRC).....	7
HRC RESPONSIBILITY:	7
DELIBERATIONS OF HUMAN RIGHTS COMMITTEE:	7
RIGHTS RESTRICTION APPROVAL PROCESS:	8
ELEMENTS OF CONSENT:	9
COMPLAINTS AGAINST COMMITTEE MEMBERS:	9
BEHAVIOR SUPPORT COMMITTEE	10
PURPOSE & PROCESS GUIDELINES OF A BEHAVIOR SUPPORT COMMITTEE (BSC).....	11
FUNCTIONAL BEHAVIOR ASSESSMENT (FBA),	13
FUNCTIONAL ANALYSIS (FA), AND BEHAVIOR PLAN (BP)	13
CONDUCTING A FUNCTIONAL BEHAVIOR ASSESSMENT	14
FUNDAMENTAL COMPONENTS OF FUNCTIONAL BEHAVIOR ASSESSMENTS:.....	14
FUNCTIONAL BEHAVIOR ASSESSMENT (FBA) OR FUNCTIONAL ANALYSIS (FA):.....	16
WHICH ONE AM I DOING?.....	16
ESSENTIAL COMPONENTS OF FUNCTIONAL BEHAVIOR ASSESSMENTS (FBAS)	17
AND BEHAVIOR PLANS (BPS)	17
FUNCTIONAL ANALYSIS INFORMATION	19
FLOWCHART TO COMPLETING A FUNCTIONAL BEHAVIOR ASSESSMENT (FBA)	20
EVIDENCE-BASED PRACTICES	21
BEHAVIORAL INTERVENTIONS	22
EXAMPLES OF BEHAVIORAL INTERVENTIONS:.....	22
COGNITIVE BEHAVIORAL INTERVENTION (CBT):	22
MODELING:	23
SCRIPTING:	23
SELF-MANAGEMENT:	23
SOCIAL SKILLS PACKAGE:.....	23
RESTRICTIVE TECHNIQUES.....	24
WHAT IS A RIGHTS RESTRICTION?	25
DESCRIPTION OF COMMON TECHNIQUES.....	28
HIERARCHY OF INTERVENTIONS:.....	30
RESTRICTIVE PROCEDURES	31
EMERGENCY PROCEDURES.....	35

EMERGENCY EVACUATION:	36
REFERENCE TO DD POLICY	37
APPENDIX	38
TITLE XIX REGULATIONS FOR ICF/ID.....	39
LICENSURE.....	42
LAWS AND REGULATIONS.....	42
CQL PERSONAL OUTCOME MEASURES	43
DD BILL OF RIGHTS	44
SAMPLE RIGHTS ASSESSMENT	45
HRC/BSC SAMPLE FORM TO GATHER THE INFORMATION NEEDED FOR RECORD KEEPING	50
HRC AND/OR BSC RESTRICTION APPROVAL/DENIAL FORM	51
BEHAVIOR SUPPORT/HUMAN RIGHTS QUESTIONNAIRE FORM	53
THE FUNCTIONAL BEHAVIOR ASSESSMENT (FBA),.....	54
BEHAVIOR PLAN (BP), AND PROGRAM IMPLEMENTATION REVIEW (PR)	54
FUNCTIONAL BEHAVIOR ASSESSMENT INTERVIEW QUESTIONS	74
SAMPLE FUNCTIONAL BEHAVIOR ASSESSMENT TEMPLATE.....	79
POSITIVE BEHAVIOR SUPPORTS STAFF TRAINING CHECKLIST	83
PHYSICAL INTERVENTION TECHNIQUES STAFF TRAINING CHECKLIST.....	84
RESTRICTIVE TECHNIQUES QUICK REFERENCE GUIDE:	85
GLOSSARY: TERMS AND DEFINITIONS	86

PURPOSE OF THIS DOCUMENT

This document is intended to offer guidance to the QDDPs, HRC/BSC Committees, and other Quality Assurance staff in the development and instruction for the committees and is not offered or intended as a definitive legal guide, nor as a comprehensive implementation manual. Please note that care was taken to highlight and identify the reference materials. Some of these materials are included as sample templates or addendums. *****Refer to DD Policy on how to implement this guidance.***

VALUES AND PHILOSOPHY

Developing specific value statements about behavior that someone exhibits can be a perilous journey simply because of the various perspectives on what the function is of that behavior. Some individuals and organizations state that only positive behavioral supports should be used with persons with intellectual and developmental disabilities and that other, more restrictive interventions, have no place in the disability services industry. This guide will provide information to assist teams in assuring that they have developed a functional behavior assessment and a behavior plan that best suits the needs of the person it was developed for.

The DD Bill of Rights (Appendix) creates a fundamental determination of a person's rights. Any modifications or discrepancies in this area are considered restrictive in nature, must be addressed by the team, included in the person's plan, and must be taken through the appropriate Committees to assure due process.

Restrictive interventions should be developed with team members and are administered consistent with the person's programs. The following information should be completed and documented in the Person-Centered Service Plan, according to OSP Instructions:

1. Identify a specific assessed need and a description for why the restrictive intervention is necessary; and,
2. Positive interventions and less intrusive methods that have been tried but were not successful; and,
3. Regular data collection and review of data to measure the effectiveness and justify the continued need for the restrictive intervention(s); and,
4. Establish time limits for reviews; and,
5. Informed consent of the person and/or legal decision maker; and,
6. Assurance that the restrictive interventions will "Do No Harm." Teams should discuss and carefully weigh the harmful effects of the restrictive intervention(s) against the harmful effects of the target behavior; and,
7. Plan to fade the restrictive intervention(s).

HUMAN RIGHTS COMMITTEE (HRC)

PURPOSE & PROCESS GUIDELINES OF A HUMAN RIGHTS COMMITTEE (HRC)

The rights of all people who are supported in the Developmental Disabilities service delivery system must be protected. As part of the due process, steps associated with client rights, each Provider Agency must ensure that there is a Human Rights Committee (HRC) in place to accomplish this mission. The HRC's role is to review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the Committee, involve risks to client protection and their rights.

HRC RESPONSIBILITY:

The Human Rights Committee is responsible for assuring that individual's rights are supported and protected through due process of the person receiving services and supports. This Committee must be held accountable to understand due process, ensure people can exercise their rights, that aspects of human rights and advocacy are upheld, and to question every situation in which a person's rights are restricted for any reason. Each Provider Agency may have its own HRC or may participate in a system wide Human Rights Committee. Restrictions should be reviewed and approved by the Committee prior to implementation.

REASON:

The accrediting, certification, and licensing bodies require that agencies providing services to individuals with intellectual and developmental disabilities have due process on any rights limitations set forth by the team process. Provider agencies will be trained on therapeutic responses or a similar positive behavioral supports curriculum within the first 90 days of employment. In the case of a behavioral program setting, staff must be trained within the first 30 days AND prior to working alone, unsupervised in this setting (per DD training policy).

DELIBERATIONS OF HUMAN RIGHTS COMMITTEE:

- Rights restrictions (money management, freedom of movement, privacy),
- Restrictive behavior plans,
- Any use of psychotropic medication(s) used for behavior management,
- All instances of alleged abuse, neglect, or exploitation of individuals served are reported to the Chairperson of the Human Rights Committee in accordance with agency policy, state law, and provisions of the appropriate DD Policy,
- Issues of informed consent
- All incident reports involving a person's rights violations and/or restrictions should be reported to the Human Rights Committee by the Provider Agency. If the incident does not involve a rights violation and/or restriction, the Provider Agency is not required to report the incident to the HRC. The Protective Service Review Committee/Quality Assurance Team may need to be responsible to review the incident report according to the incident report according to the requirements of appropriate DD policy.
 - Providers must document whether the incident was reported to the HRC; and, if the incident was reported to the HRC, the date of notification. This can be accomplished by noting it on the Investigative Action Level Checklist or documenting it in the internal investigation report (GER).
 - If no rights are restricted, no notification is necessary. Provider Agencies should document when a restriction has been reported to the Human Rights Committee, who was contacted, and then maintain a copy of this approval for all restrictions.

Plans that are taken through the Human Rights Committee should be approved at least annually, or sooner if the Committee feels that the restriction can be faded or may not be necessary for the year (i.e., approval for door chimes but the roommate who needs it will be moving out and these will go away when they leave). Approval timelines for physical interventions and medication(s) used for behavioral support should not exceed a period of six months. Timelines for approval of other rights restrictions should not exceed one year.

MISSION:

The purpose of the Human Rights Committee (HRC) is to promote, safeguard, and protect the dignity, legal rights, and liberties of individuals with developmental disabilities, as well as ensure the rights of the individuals served are afforded due process by a thorough review conducted by the HRC.

PURPOSE:

The Human Rights Committee (HRC) is committed to ensuring that any rights limitations presented are considered the least restrictive procedure possible. It is the responsibility of the HRC to assure that the interdisciplinary team has tried the alternatives of teaching replacement behaviors before moving to more restrictive measures. The HRC is committed to protecting the rights of the individual(s) served, as well as assuring the greatest respect of everyone's human rights, and to ensure that any restriction or limitation is temporary in nature.

The HRC has, as its focus, the assurance of the rights of the individual(s) served. Each team member working with individuals served must commit themselves to treating people with dignity and respect and be able to accept people for who they are, unconditionally. With this in mind, it is the intent of the HRC to ensure that all punishing consequences are abolished and that the most positive approaches are utilized at all times.

RIGHTS RESTRICTION APPROVAL PROCESS:

Upon presentation regarding the specifics of a program plan and rights restrictions, the Human Rights Committee would review, approve, and monitor programs designed to address behavior and other programs that, in the opinion of the Committee, involve risks to the person's protection and rights. A plan for restrictions to be removed would also be in place.

In order to limit any rights, an individual has:

1. The risk to the person by allowing them full recognition of this right outweighs the risk the limitation would have on the person.
2. The person will clearly benefit from the limitation (versus convenience for others).
3. All other options/alternatives (that are less restrictive) have been examined/attempted/documented.
4. Due process is adhered to.
5. The Person-Centered Plan documents the restrictions.
6. Consent is required (person and/or guardian, Behavior Supports Committee, Human Rights Committee, Administration, etc.).

ELEMENTS OF CONSENT:

- The person's decision must be voluntary.
- The person must be thoroughly informed of the risks and potential impacts of the decision.
- The person has capacity to make decisions on their behalf.

COMPLAINTS AGAINST COMMITTEE MEMBERS:

The Committee will determine the validity of the allegation, and if the allegation is determined to be true, will determine appropriate action(s) to be taken. The member may be asked to leave while the Committee decides the action to be taken.

BEHAVIOR SUPPORT COMMITTEE (BSC)

PURPOSE & PROCESS GUIDELINES OF A BEHAVIOR SUPPORT COMMITTEE (BSC)

The Behavior Support Committee (BSC) is committed to teaching only positive behavioral supports and alternative skills. It is understood that the purpose to any behavior is communication and it is the responsibility of the interdisciplinary team to ensure that a plan is in place to assist the person in communicating more positively. It is the responsibility of the Behavior Support Committee to assure that the interdisciplinary team has identified the meaning of the behavior and there is a mechanism in place that can help the individual learn a new way to communicate the meaning of their behavior. Behavior support refers to efforts to increase socially adaptive behaviors. The goal is to teach behaviors and skills that are adaptive and socially productive.

PURPOSE:

The purpose of the Committee is to promote, safeguard, and protect the dignity, legal rights, and liberties of individuals with intellectual and developmental disabilities.

Each team member working with individuals served must commit themselves to treating people with dignity and respect and be able to accept people for who they are, unconditionally. It is the intent of the Behavior Support Committee to ensure that all punishing consequences are abolished and that the most positive approaches are utilized.

BEHAVIOR SUPPORTS COMMITTEE RESPONSIBILITY:

“Peer Review of Behavior Support Committee” (variously titled Behavior Management Committee, Behavior Intervention Committee, or Positive Behavior Supports) is the agency or regional Committee responsible to review individual behavior plan programs designed to eliminate or reduce maladaptive behavior and replace them with behavior and skills that are adaptive and socially productive. Programs that call for any restrictive procedures would be submitted to the Committee for review prior to implementation to ensure that the proposed intervention is likely to produce the desired effect, and that any risks to the person receiving services are outweighed by the risks of the behavior.

All behavior plans that are being implemented to modify or change a person’s behavior should have a Functional Behavior Assessment (FBA)/Functional Analysis (FA) completed that drives what will be implemented in the Behavior Plan (variously titled Behavior Intervention Plan, Behavior Support Plan, Positive Behavior Support Plan, etc.). All plans that are attempting to modify a behavior or involve techniques that involve restraints (physical, mechanical, or chemical) should have the person’s team and Behavior Support Committee’s approval prior to the implementation of the behavior plan. Behavior plans should be reviewed a minimum of every six months, or sooner if needed, and in accordance with current DD Policy.

All behavior plans with restrictions should be taken through both the Human Rights Committees and the Behavior Support Committee, with Human Rights Committee reviewing last. The two Committees should act independently of each other and Provider Agencies would need to seek approval from both Committees before implementing the behavior plan.

DELIBERATIONS OF BEHAVIOR SUPPORT COMMITTEE:

The Behavior Support Committee should review the following items prior to approval:

- Have the restrictions been identified?

- Is the function(s) of the person's behavior clearly defined (has a Functional Behavior Assessment (FBA) or Functional Analysis (FA) been completed), reviewed annually, and updated as needed?
- Have other factors been considered or ruled out as causes for the behavior (e.g., medical, environmental, psychiatric, etc.)?
- Are they based on an assessment of the function of the behavior, including, but not limited to, the communicative intent of behavior?
- Does the person have a Positive Behavior Support Plan, Behavior Plan, or similar plan of strategies that include techniques from an evidence-based practice or curriculum to help the person be more successful?
- Is the use of psychoactive medication(s) based on a specific psychiatric diagnosis?
- Does the person take medication(s) for behavior management (e.g., is the use of psychotropic medication(s) for behavior support recognized as a chemical restraint and considered highly intrusive/restrictive)?
- Are formal Behavior Plans implemented only after the team has ruled out physical and environmental issues contributing to a person's behavior?
- Do behavior plans include teaching alternative communication and coping strategies?
- Is there a plan/mechanism in place that can help the person to learn a new way to communicate the meaning of their behavior (i.e., a functionally equivalent way to communicate)?
- Does the proposed behavior plan incorporate the least restrictive approach, and includes a plan to fade and review the restrictive procedure(s) or medication(s)?
- Is there clear evidence that lesser restrictive or intrusive procedures have been tried and not been effective?
- Are behavior plans that include highly intrusive procedures or other restrictive techniques implemented only with the prior written informed consent of the person or the person's legally authorized representative?
- Is the Committee convinced that the proposed behavior plan is the least restrictive approach for this person?

Any programs which incorporate restrictive techniques (e.g., restraints, medication to manage behavior, restrictions on community access, etc.) have been reviewed and approved by the Behavior Support Committee prior to implementation and training of staff.

*****NOTE: Agency Providers may have a combined HRC/BSC as long as the committee makeup and all due process procedures for both are implemented by the combined Committee.***

FUNCTIONAL BEHAVIOR ASSESSMENT (FBA), FUNCTIONAL ANALYSIS (FA), AND BEHAVIOR PLAN (BP)

CONDUCTING A FUNCTIONAL BEHAVIOR ASSESSMENT

Current thinking regarding challenging behavior recognizes the success of an intervention depends on understanding why a person responds in a certain way and teaching the person a more suitable method of getting that same need met. The process of uncovering why a person responds in a particular way is called a Functional Behavior Assessment, or FBA. Conducting a Functional Behavior Assessment is the first step when starting to create a behavior support plan, and it helps the team understand what factors in the environment influence behavior. Information that is collected will usually include:

- An understanding of events which occur immediately before the behavior (antecedents or stress triggers).
- An understanding of what happens right after the behavior (consequences);
- Previously used treatment efforts and their relative effect or impact on the behavior.
- Potential effects of the physical environment, including:
 - noise levels;
 - brightness;
 - furniture arrangements;
 - potential crowding factors such as the size of the room and the number of people in the immediate vicinity;
- Any possible health or medical factors which may influence the person;
- Where the behavior tends to occur most often, as well as least often.

This information typically is gathered through direct observations of the person across various environments, as well as through a review of the person's records. After reviewing the information and observing the person, it is necessary for the team to develop a hypothesis regarding what they consider to be the reason(s) for the behavior. The most frequent possibilities include seeking attention, task or social avoidance, sensory input, physical illness, and/or mental health concerns.

FUNDAMENTAL COMPONENTS OF FUNCTIONAL BEHAVIOR ASSESSMENTS:

One fundamental component of the FBA process is an A-B-C analysis, where "A" stands for antecedent events, "B" for the precisely defined behavior, and "C" for any consequences following the behavior. Most often, every time the behavior occurs, a caregiver will complete a data sheet on which information is detailed about these three factors.

A: Antecedents. These are events that seem to reliably predict the occurrence of the behavior. These might be relatively complex things such as requests to complete work assignments, changes in lighting or noise levels within a setting, the onset of a headache or other physical illness, or an increase in screaming by peers within an environment. Sometimes antecedents can be seemingly simple events, such as flipping a light switch, changing directions in a car, or even physical affection.

B: Behavior. The behavior of concern must be defined in detail so that all persons involved can reliably measure it when it occurs. Simply recording "aggression" is not good enough - what kind of aggression? Verbal? Physical? Against property or others? Hitting, kicking, spitting, biting, slapping, or all of the above? Precise definitions allow the team to know the data is reliable, thus promoting good treatment decisions.

C: Consequences. These are events which occur immediately after the behavior and the goal is to identify the specific activities, food items, forms of attention, and/or other reinforcing events that help maintain the behavior. Once identified, these reinforcers can often be rearranged to help teach appropriate replacement behaviors and minimize the occurrence of the challenging behavior.

It is important remember that the function of a behavior can change over time. Though initially a behavior may serve to avoid an unpleasant task or request, later that same behavior might serve to gain attention from peers or other caregivers. Consequently, it is helpful to continue the assessment process even after starting a treatment intervention, as this allows the team to understand any changes in the behavior that might occur, and make changes in the support plan based on a function that might change.

Another helpful component is the scatterplot analysis, which provides temporal details about challenging behaviors over the course of each day. Scatterplot analyses help uncover whether specific behaviors occur around predictable periods of time. If this is the case, changes in routines or schedules should occur to prevent these situations. A portion of a sample scatterplot is shown below:

Behavior: self-injury (slapping face with open hand which causes redness)

Time		1	2	3	4	5	6	7	8	9	10
0600-0630			√				√	√			
0630-0700			√	√		√	√			√	√
0700-0730						√					
0730-0800						√					
0800-0830		√	√				√	√		√	
0830-0900						√	√				
0900-0930						√					
0930-1000					√						
1000-1030						√					
1030-1100						√		√			

In this example, it is reasonable for the person's team to first look at the events occurring around the 0600-0700 time periods. Perhaps this is when the person is first waking - is there a need for a change in wake-up routine? If this is breakfast time, additional information can be collected to assist in understanding what might be happening and where changes might be in order. Similarly, from 0800-0830 there also are several self-injury incidents - what is happening during this period? What can be changed? The 5th day of this month is also a day with several incidents of self-injury - what happened this day? Was the person ill? Was a favored caregiver absent? What happened that might explain the behavior? When multiple days are viewed this way, patterns often can be seen, and plans can be changed to help support the person through difficult times.

Additional tools are interview forms, which ask questions to assist the team in understanding what function a behavior might serve. A popular tool is the Functional Analysis Screening Tool, or the FAST. Another is the Motivation Assessment Scale, or MAS.

FUNCTIONAL BEHAVIOR ASSESSMENT (FBA) OR FUNCTIONAL ANALYSIS (FA): WHICH ONE AM I DOING?

A functional behavior assessment (FBA) is defined as a systematic method (process) of obtaining information related to the purpose (function) of a behavior. Differentiation of methods are categorized three ways: indirect methods, direct methods, and experimental (functional) analysis:

- Indirect methods include structured interviews, checklists, rating scales, or questionnaires completed by someone who knows the person who engages in target behavior and is based on their recall of the behaviors over time.
- Direct methods include observation of the behavior in relation to events that occur within the environment and include both descriptive methods (narrative), checklist method (data collected at the time the behavior takes place), or continuous data recording (interval recording), and scatterplots.

Components of a Functional Behavior Assessment (FBA)		
Indirect Methods Include:	Direct Methods Include:	Functional Analyses (FA) Include:
Structured interviews	Observation of Behavior	Explicit and systematic manipulation or experimental analysis of the functional relationship between behavior and environment
Checklists	Descriptive Methods (narrative)	
Rating Scales	Checklist Method (data collected in real time)	
Questionnaires	Continuous Data Recording (interval recording)	
	Scatterplots	

The FBA process is a 4-step process. The first step is gathering information via direct and indirect descriptive assessment. Step two is interpreting the information obtained in step one and formulating a hypothesis about the function (purpose) of each behavior. Step three moves into testing the hypothesis using **FUNCTIONAL ANALYSIS**. Step four is using the information obtained to develop behavior intervention strategies based on the function of the behavior.

A **FUNCTIONAL ANALYSIS** should only be conducted by a **qualified professional** (Licensed Behavior Analyst/Assistant Behavior Analyst, or a Licensed Psychologist), if it is within their scope of practice. After a Behavior Plan has been determined to be unsuccessful in changing a person's behavior, the team should consider consulting with a qualified professional to conduct a Functional Analysis.

In summary, a Functional Behavior Assessment (FBA) is a general term used to describe the process of gathering information related to a target behavior. There are three categories of methods to collect information. The information obtained from these methods is used to develop behavior intervention strategies based on the function of the target behavior.

Basic Steps to Completing an FBA	
1. Gather information via Indirect Methods and Direct Methods.	
2. Interpret information gathered in step one. Formulate a Hypothesis about the function of the behavior.	
3. Testing the hypothesis via FUNCTIONAL ANALYSIS (optional if not needed).	4. Use the information obtained to develop a Behavior Plan.

ESSENTIAL COMPONENTS OF FUNCTIONAL BEHAVIOR ASSESSMENTS (FBAs)
AND BEHAVIOR PLANS (BPs)

1. Input obtained from multiple sources (day, work, home, family, school, etc.).
 - a. Referral Information:
 - Most significant issue/behavior of concern
 - Why is this behavior a concern? (Social Validity)
 - Who is the contact person/source of referral?
 - Diagnostic list
 - Information sources
 - b. Records Review:
 - Test scores
 - Medical history including medications
 - Social and behavioral history
 - What has been tried in the past? What was the response to those previous strategies?
2. Behavior that is the focus of the Functional Behavior Assessment (FBA) is identified and defined in measurable terms.
 - a. Identify & Define Target Behavior(s):
 - Written objectively and operationally to indicate that anyone who reads the definition would be able to observe the beginning and ending of each occurrence of the behavior.
 - Definition can produce observable and measurable data for baseline and for following the implementation of a behavior plan.
 - Antecedent(s) to the target behavior, triggers, and setting events
 - Consequence(s) to the target behavior, possible maintaining contingencies (function of behavior).
 - b. Interview:
 - Indirect measures (checklists, interviews, anecdotal notes, etc.)
 - Identify who to interview (family, guardian(s), sibling(s), direct care providers with significant time spent with the individual).
3. Baseline data, done over an extended period of time (i.e., 2 weeks) is provided on the identified behavior.
 - a. Direct Observations & Data Collection:
 - Antecedent behaviors and triggers or setting events
 - Consequences/maintaining contingencies
 - Frequency, duration, and time samples (data collection measures)
 - Must be done over an extended period of time (i.e., 2 weeks)
 - Look at staff and environment
4. Setting events are considered and identified if pattern of predictability is present.
5. Antecedent event triggering behavior(s) are identified and described adequately.

6. Antecedent events present when no behavior occurs are identified and described adequately.
7. Responses made by others following the behavior occurs are identified and described adequately.
8. Hypothesis statement is clearly written and uses the information from the FBA.
 - a. Determine the function of the behavior(s)
 - Each behavior must be identified separately.
 - May need to conduct a **FUNCTIONAL ANALYSIS** (experimental analysis). This **MUST** be done by a Licensed Behavior Analyst or a licensed professional with additional certifications/competencies, with observations and record reviews.
 - Checklist coupled with observations and record reviews.
 - Function is based out of research (access or escape).
9. Function in hypothesis is valid (i.e., escape/avoid/delay; access/obtain items/attention, automatic).
 - a. **POSITIVE REINFORCEMENT** – The offering of a stimulus that, when presented as a consequence of a response, results in an increase or maintenance of that response.
 - b. **NEGATIVE REINFORCEMENT** – The offering of a stimulus that an individual will work to avoid or escape.
10. Behavior Plan is developed in a timely manner after the FBA has been completed.
 - a. Develop and Implement Behavior Plan:
 - Must be developed if behavior interferes with individual's learning.
 - Must be based on assessment data.
 - Must be individualized to meet the client's needs.
 - Must include positive behavior strategies and supports.
 - The effects of the Behavior Plan must be monitored (i.e., collect data as to identify the prevention strategies being used).
11. Hypothesis from FBA is included or referenced in Behavior Plan.
12. A minimum of one antecedent strategy is described that links with the hypothesis and provides enough detail so that it would be implemented consistently each day by multiple people.
 - a. **ANTECEDENT/PROACTIVE/PREVENTION STRATEGIES:** anything that occurs before or prior to a target behavior ever occurring that eliminates or makes the antecedents less of a trigger to the target behavior occurring.
13. A minimum of one teaching (i.e., functionally equivalent replacement behavior or alternative skill) strategy is described that links with the hypothesis and provides enough detail so that it could be implemented consistently each day by multiple people.
 - a. **TEACHING STRATEGIES:** instructional procedures which involve the use of rearrangement or presentation of stimuli from both the physical and social environments to increase the probability of appropriate behavior (e.g., prompting, giving instruction, demonstrating, modeling, suggesting alternatives, giving graduated guidance, providing cues, and removing

provoking/tempting stimuli).

- Plan specific to replacement behavior.
- Based on the function of the behavior(s).
- Based on observation of record reviews.
- Must be observable and measurable.
- Functionally equivalent of target behavior OR incompatible of target behavior.

14. A minimum of one reinforcement strategy is described that links with the hypothesis (i.e., provides the function) and provides enough detail so that it could be implemented consistently each day by multiple people.

15. A minimum of one strategy that changes the response after problem behavior is present, is linked with the hypothesis, and provides enough detail so that it could be implemented consistently each day by multiple people.

- a. **CONSEQUENTIAL/REACTIVE/RESPONSE STRATEGIES:** any strategy that is applied following the occurrence of a target behavior in response to that behavior occurring.

16. A crisis plan was considered and if necessary, is described in enough detail so that it could be implemented consistently each day by multiple people.

- a. Safety Planning: Use of Therapeutic Response/**PHYSICAL RESTRAINT**

17. An evaluation plan for determining effectiveness is described.

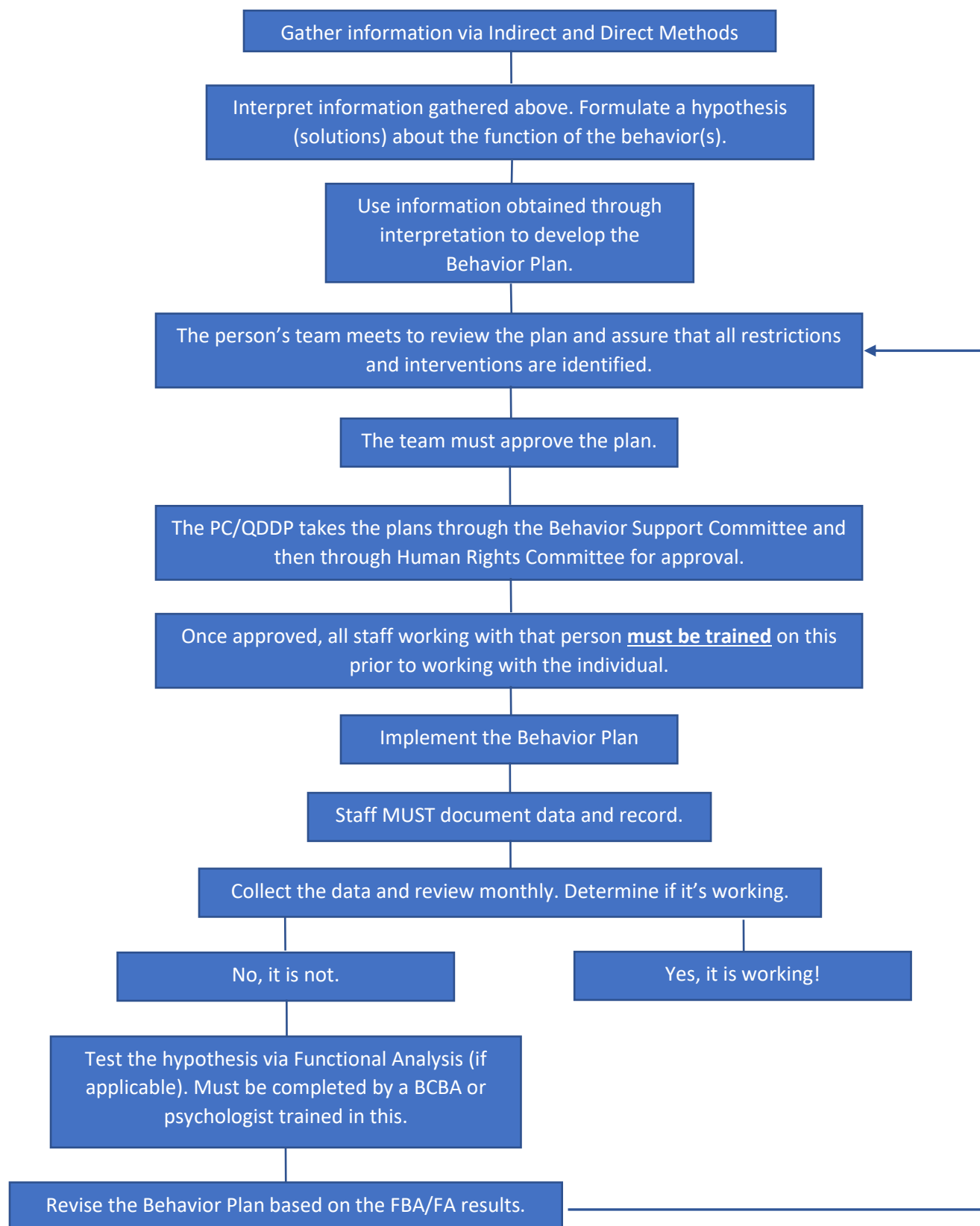
18. A plan for measuring fidelity is described.

19. The plans should be reviewed at least annually and updated as needed throughout the year.

FUNCTIONAL ANALYSIS INFORMATION

A **FUNCTIONAL ANALYSIS** should only be conducted by a **qualified professional** (Licensed Behavior Analyst, Licensed Assistant Behavior Analyst, or Licensed Psychologist), if it is within their scope of practice. After a Behavior Plan has been determined to be unsuccessful in changing a person's behavior, the team should consider consulting with a qualified professional to conduct a Functional Analysis.

FLOWCHART TO COMPLETING A FUNCTIONAL BEHAVIOR ASSESSMENT (FBA)



EVIDENCE-BASED PRACTICES

Evidence-Based Practices are:

- Consistent and reliable evidence that the interventions (practice, program, curriculum, etc.) has been proven to be effective.
- Involves the application of rigorous, systematic, and objective procedures to obtain reliable and valid knowledge.
- Includes research that:
 - Employs systematic, empirical methods.
 - Involves rigorous data analysis.
 - Relies on measurements that provide reliable and valid data.
 - Uses experimental or quasi-experimental designs.
 - Ensures that studies are clear and detailed to allow for replication.
 - Has been reviewed or accepted by independent experts.

Important factors to consider when implementing evidence-based interventions:

- Adhere closely to details of how it was implemented in the research.
 - Is the intervention being implemented as it was described in the research?
 - Was anything left out or added that was not in the original research?
 - Is there fidelity? (accuracy in details, exactness)
- Collect data to determine whether the intervention is effective.
- Knowing what practices are effective is essential, other factors must also be taken into considerations:
 - Research findings
 - Professional judgement
 - Values and preferences
 - Capacity (proper training, adequate resources, and ongoing feedback about treatment fidelity)

BEHAVIORAL INTERVENTIONS

Comprised of interventions typically described as antecedent and consequent interventions.

- Antecedent interventions look at altering events that precede the occurrence of a target behavior.
- Consequent interventions look at altering events that follow the occurrence of a target behavior.

Typically, these interventions focus on prevention of behavior, teaching appropriate functional communication skills, reinforcing appropriate skill and not reinforcing the behavior through these basic principles:

- Modify activities, materials, or schedules (Prevention)
- Incorporating individual's preferences (Choice)
- Preparing for changes
- Varying the format, level of difficulty, or order of instruction
- Enriching the environment to provide additional cues or materials.
- Modifying prompting and reinforcement schedules and delivery.

EXAMPLES OF BEHAVIORAL INTERVENTIONS:

- Chaining (forward or backward)
- Differential reinforcement
- Function-based interventions
- Reinforcement schedules
- Repeated practice
- Extinction + Reinforcement
- Function-based intervention + Prompts
- Stimulus fading + positive reinforcement
- Augmentative and Alternative Communication (AAC) Devices
- Choice + Task interspersal+ positive reinforcement
- Discrete trial training (DTT) + Natural consequence + Error correction
- Most-to-Least Prompting + Natural consequence + Activity interspersal
- Pre-teaching + Prompting + Positive reinforcement
- Video Modeling + DRA + Escape Extinction + Stimulus fading + Photo prompting

COGNITIVE BEHAVIORAL INTERVENTION (CBT):

- Manualized cognitive behavioral intervention
- Educational component to identify and describe thoughts, feelings, and emotions, physical responses to emotions, and prevalence of these concerns with other people.
- Strategies to alter thoughts and emotions that are uncomfortable.
- Development of scale to measure uncomfortable feeling (scale, ladder, volume control, etc.)
- Homework assignments – to practice new skills or activity
- Parent sessions
- Some manualized interventions include The Coping Cats Program and Exploring Feelings
- Professional should be trained in cognitive behavioral interventions prior to implementation.

MODELING:

- Demonstrate how to correctly perform a desired target behavior.
- There are two types: live and video
- For best results:
 - List the steps for correct implementation of the target behavior, write the steps down.
 - Ensure all who model the target behavior are doing so correctly (see written steps).
 - Obtain person's attention prior to modeling the behavior.
 - Develop a plan to fade or stop the use of the modeling to encourage independence.
 - For video modeling, pre-record the person demonstrating the target behavior. When person views the recording, point out the important steps.

SCRIPTING:

- Scripts are developed to provide instruction regarding how to use language to initiate or respond in a certain situation.
- Scripts can be verbal or written.
- Reflect a specific skill or situation.
- Practiced repeatedly before the skill is used.
- Ensure the person has the prerequisite skills (imitation, reading).
- Used with reinforcement, modeling, and/or prompting.
- Can be successful in a variety of social situations.
- Should be faded as soon as possible to avoid dependence.

SELF-MANAGEMENT:

- Teach the person to identify appropriate and inappropriate behavior, accurately monitor and record their own performance, provide reinforcement for performing the appropriate behavior.
- Self-management has been used to teach appropriate skills, social behavior, and monitor disruptive problem behavior.
- Self-management is faded over time.
- Prerequisite skills: the person can perform the skill; will work independently for reinforcement.
- Clear behavioral criteria.
- Checklist or other systematic method for evaluating performance.
- Initially focus on providing feedback for accuracy of monitoring.
- Fade the cues given by others during self-management.

SOCIAL SKILLS PACKAGE:

- Goal is to teach the skills needed to meaningfully participate in the social environments of home, school, work, or community.
- Basic concepts (what the skill is, how to perform it, etc.).
- Some social skills include: recognizing facial expressions, turn-taking in conversations, initiating an interaction, problem solving.
- Behavior Skills Training (BST) is effective in teaching social skills.
 - Define the skill; Write it down; Model; and Role-play or practice with feedback.

RESTRICTIVE TECHNIQUES

WHAT IS A RIGHTS RESTRICTION?

This is not an all-inclusive list and the restrictions are defined for each person served. A rights restriction for one person, may not be for another. Please review the ND Bill of Rights as well as the United Nations Declaration of Rights with the person and their team.

Some considerations for a team, when making a determination for a rights restriction, may include:

1. Is it a right identified in the DD Bill of Rights or UN Declaration of Rights?
2. Is this something you would consider a restriction for yourself?
3. What rights are important to the person?
4. How does the person react?
5. Are high expectations being imposed?
Expectations should be reasonable and attainable.
Would you hold yourself to that level?
6. Restrictions should not be in place because it is annoying or offensive to some. People do not need “fixing” or to be controlled. Instead, it is important to mediate health/safety risks.
7. People have different ideas on what risk is: risks may depend on the person, their skills, history, preferences, what has been learned, etc.
8. Is there documented information for the need and documentation is reviewed to justify continuing the restriction?
9. Is this the least restrictive intervention and positive behavior supports, education, replacement behaviors, and fading is included?
10. Be cautious with people having to “earn” what is rightfully theirs.
11. Brainstorm creative solutions and regularly explore other ideas, strategies, retry solutions, use of technology, etc.
12. If a restriction is not needed for a period of time, there should be discussions if it’s appropriate to remove or fade.

Rights Summary from The Arc:

People with intellectual and/or developmental disabilities (I/DD) have the same basic legal, civil, and human rights as other citizens. They may need accommodation, protection, and support to enable them to exercise these rights. Their rights should never be limited or restricted without due process.

If you answer any of these areas where the person is not able to move freely about in their environment, make their own decisions or do what they want, these would all be rights restrictions and should be taken through the Human Rights Committee prior to implementing the restriction. All restrictions should be reviewed at least annually.

A person’s rights should never be restricted based on Provider rules or staff preferences. Any restriction of rights should be based on the person’s unique clinical needs and need to be documented and approved by the local/Provider Agency’s Human Rights Committee. All people living in provider owned or controlled residential settings have rights which should not be restricted without assessed need and documentation. These rights include, but are not limited to, the ones outlined in the table below.

If a guardian requests a restriction, this alone is not a justified reason to implement. Approving or not approving a restriction should be considered the same way for any other restriction. There must be an

individualized, justified need and less restrictive measures attempted. Guardians may benefit from education on rights, importance of due process, what right restrictions are, philosophy of services, normalization, etc. It may be helpful to also share with guardians any observations, physical reactions of the person, non-verbal communication, what rights are important to the person, various assessment findings, etc.

Example of Rights	Examples of Inappropriate Rights Restrictions
<u>Freedom of Privacy:</u> Cameras	<ul style="list-style-type: none"> • Camera is in a person's bedroom to monitor attempts to leave through the window. • Cameras are in the common areas to monitor staff. • Cameras are used to replace staffing.
<u>Freedom of Movement:</u> Bed rails	<ul style="list-style-type: none"> • Person has bed rails to prevent from getting up during the night for a snack. • Bed rail is used without an assessment being completed.
<u>Freedom of Movement:</u> Seat/chair belts (safety vs. required)	<ul style="list-style-type: none"> • Having a recliner footstool put up and the person cannot put it down independently and meant to keep the person in the chair. • Buckle guards on seatbelts or moving the seatbelt clasp to the back so the person cannot independently unbuckle self without a safety concern and without adequate due process.
<u>Personal Possessions:</u> Money	<ul style="list-style-type: none"> • Everyone has their money locked in the staff office due to provider policy. • Person earns money from a reward plan that comes from their employment paychecks (should not have to re-earn money already earned).
<u>Freedom of Choice:</u> Marriage, Dating, Sexual Relationships	<ul style="list-style-type: none"> • A person wants to get married but guardian does not feel they are quite ready yet, but guardian lacks authorization to make that decision.
<u>Freedom of Choice:</u> Voting	<ul style="list-style-type: none"> • Not being allowed to, or supported to, vote, or educated on candidates, but guardian lacks authorization to restrict the right to vote.
<u>Freedom to Make Decisions:</u> Guardianship	<ul style="list-style-type: none"> • Restriction is approved just because the guardian requests it. • Guardianship is pursued because person makes poor decisions in relationships and does not follow doctor orders at times.
<u>Freedom of Choice:</u> Religion	<ul style="list-style-type: none"> • Person wants to participate in a sweat lodge ceremony but is not assisted because the team does not feel it would be helpful. • Everyone attends the same Catholic church but not all roommates are Catholic, and some would like to attend another church.
<u>Personal Possessions:</u> Electronics	<ul style="list-style-type: none"> • Uses internet to search out porn - All electronics are restricted. • Parental controls to shut down during certain time periods. • Taking away remotes; removing power cords; locking up; putting out of reach/hiding devices. • Limiting access contingent on completing tasks/chores ("You can't watch TV until your clothes are folded and put away.")
<u>Personal Possessions:</u> Clothing	<ul style="list-style-type: none"> • Certain clothing is removed from possession because it is too provocative. • Clothing is thrown away without consent.
<u>Personal Possessions:</u> Keep their own items	<ul style="list-style-type: none"> • Certain personal products (e.g., shaving razors) are locked for everyone because that is provider policy.
<u>Freedom of Privacy:</u> Room searches	<ul style="list-style-type: none"> • Doing room searches because they are not supposed to have food in their room; or the person steals items.

Example of Rights	Examples of Inappropriate Rights Restrictions
<u>Personal Possessions:</u> <u>Freedom of Privacy:</u> Send and receive mail	<ul style="list-style-type: none"> Person is unable to read, so staff read and open all mail assuming person is not interested in what arrives. Letters cannot be sent without staff approving the content.
<u>Freedom to Make Decisions:</u> Medical decisions	<ul style="list-style-type: none"> Use of birth control, but guardian lacks authorization to make that decision. Restrictive diets recommended by a physician without adequate risk and/or oversight by medical professionals.
<u>Freedom to Make Decisions:</u> <u>Freedom of Choice:</u> Medications to change behavior	<ul style="list-style-type: none"> Person takes medication to decrease aggression, past 2 years of data shows that aggression is no longer prevalent; or data is not being collected to monitor the frequency/intensity of the behavior.
<u>Freedom of Choice:</u> Dietary restrictions/suggestions	<ul style="list-style-type: none"> Person has Prader-Willi, so all food is Locked for everyone in the home with the roommates not being able to access food when they want. Person has high cholesterol and can only go to McDonalds when it is listed on the menu.
<u>Personal Possessions:</u> Locked items in homes	<ul style="list-style-type: none"> All knives are locked up just because knives are not safe, and someone may cut themselves. Locked medications per agency policy. Locked laundry room for just one specific person in the home, and others cannot access.
<u>Freedom of Movement:</u> Door/Window/Bed Alarms	<ul style="list-style-type: none"> There are door alarms at each entrance, but no one has a risk of eloping. There are bed alarms without the risks of fall present to justify.
<u>Freedom of Privacy:</u> Audio Monitors (bedroom)	<ul style="list-style-type: none"> Monitor is used and there is no relevant medical condition. Monitor is used to replace staffing.
<u>Freedom of Movement:</u> Restricted Access to Home	<ul style="list-style-type: none"> Person's wheelchair is shut off/brakes locked and told it is time to "cool down" after yelling/swearing at staff. House keys are only provided to staff.
<u>Freedom of Choice:</u> Have visitors at any time	<ul style="list-style-type: none"> Cannot have visitors after 8:00pm because everyone needs to be in bed by 9:00pm. Scheduled visiting hours are imposed on the entire home.
<u>Personal Possessions:</u> Use of the phone	<ul style="list-style-type: none"> History of calling 9-1-1 five years ago, now not allowed to access the phone. Only allowed to call family twice per week.
<u>Personal Possessions:</u> Furnish living area	<ul style="list-style-type: none"> Person is told that the house is furnished, and they are unable to have their favorite recliner. Personal décor is only allowed in bedrooms.
"House Rules"	<ul style="list-style-type: none"> Establishing a set of rules for all people living in the home (without due process and not tied to an individual's own choice). Consequences implemented when the House Rules are not followed.

DESCRIPTION OF COMMON TECHNIQUES

This is a list of common techniques. Each Provider Agency should have a hierarchy of approved techniques they are currently utilizing as an agency within their policies and is trained by the Provider Agency. This document should be available to the DD Division, Protection & Advocacy, Health Facilities, DD Program Manager(s), CQL, and other entities involved in the service delivery process. Consistent with the accepted practices and philosophy of “least restrictive,” the following techniques are offered as a descriptive guide for use in specific situations. Each person served should have their own identified list of techniques, specific to them, based on their unique needs. These techniques should be documented in their Behavior Plan, Risk Assessment, and Overall Service Plan with approval from Committee(s) prior to implementation. ****NOTE: This list is not all-inclusive and there may be acceptable variations on these techniques from service provider to service provider.**

PROTECT/ESCAPE:

- Use of Environment (i.e., putting a sofa between you and the aggressor, knowing where the door is, never backing yourself into a corner).
- Use of something soft (i.e., using a pillow to block).
- Block whenever possible.
- Encourage others to leave the area.
- Provide verbal prompts.

CLOTHING, WRIST/ARM, BITE, HAIR, HEADLOCK, AND CHOKE RELEASE:

- Begin by assessing the situation. Can you allow the situation to de-escalate on its own or it is imperative that you respond?
- Ignore and withdraw attention/reinforcement.
- Remain calm and maintain an open stance.
- Provide verbal prompts and ask the person to let go (repeat, if necessary).
- If your assessment of the situation results in a determination that **PHYSICAL INTERVENTION** is needed, the appropriate release intervention can then be implemented.

ESCORT, COME-ALONG, OPEN ‘C’ WITH REDIRECTION WITH ONE OR TWO HANDS, PHYSICAL ESCORT:

- Begin by assessing the situation. Can you allow the situation to de-escalate on its own or is it imperative that you respond?
- Ignore and withdraw attention/reinforcement.
- Remain calm and maintain an open stance.
- Provide verbal prompts and ask the person to go where you would like them to go.
- If your assessment of the situation results in a determination that **PHYSICAL INTERVENTION** is needed, the least restrictive intervention should be used first with a continuation or change made only if the situation necessitates a higher level of intervention. The intervention should be faded as soon as the person is calm.

PHYSICAL RESTRAINT:

- Begin by assessing the situation. Can you allow the situation to de-escalate on its own or is it

imperative that you respond?

- Ignore and withdraw attention/reinforcement.
- Remain calm and maintain an open stance.
- Provide verbal prompts appropriate for the situation.
- If your assessment of the situation results in a determination that **PHYSICAL INTERVENTION** is needed, a one-person **RESTRAINT** should be attempted first, with a second and/or third person entering the **RESTRAINT** only if needed. The intervention should be faded as soon as the person is calm.

PHYSICAL LIFT/LIFT AND CARRY TECHNIQUE:

- Begin by assessing the situation. Can you allow the situation to de-escalate on its own or is it imperative that you respond?
- Ignore and withdraw attention/reinforcement.
- Remain calm and maintain an open stance.
- Provide verbal prompts appropriate for the situation.
- If your assessment of the situation results in a determination that **PHYSICAL INTERVENTION** is needed, a physical lift/carry can be implemented. Ensure that proper technique is used to prevent injury to the client and staff.

MEDICATION (PRN, AS NEEDED):

- At times, individuals served may be prescribed medication on an as needed basis to assist with the support of their behavioral needs. If this is the case, ensure the following:
 - Ensure that there is a current physician's order for the medication(s) and that the use of the medication(s) is clearly understood.
 - Ensure the client has a written plan to include lesser restrictive alternatives and steps to take prior to the administration of the medication.
 - The client should first be asked if he/she would like to take the medication and administration should then occur upon agreement.
 - CQL and Title XIX regulations may also address the use of PRN medications.

*****Note: Person-specific restrictive intervention techniques should always be utilized consistent with an approved behavior plan when a target behavior is being exhibited – IF THERE IS A PLAN, FOLLOW IT.***

HIERARCHY OF INTERVENTIONS:

(Applies to both plan development and emergency use)

	THERAPEUTIC INTERVENTION	Therapeutic Responses through Positive Behavior Supports
Non-restrictive	<ul style="list-style-type: none">• Do Nothing• Ignore the Behavior• Gestural Prompt• Verbal Prompting• Re-direction• Calming Techniques• De-escalation• Blocking• Planned Ignoring• Physical Prompt	<ul style="list-style-type: none">• Do Nothing• Ignore the Behavior• Gestural Prompt• Neutral presence and open stance• Verbal Prompting• Calming techniques• De-escalation• Planned Ignoring• Re-direction with Physical Prompt
Restrictive	<ul style="list-style-type: none">• Guided Compliance• Physical Hold• Finger Peel• Release Techniques:• Finger• Choke• Wrist• Clothing• Bite• Hair• Headlock• One- or two-person escort/come-along• Basket Hold Restraint (Non-floor)• Physical Lift• PRN Medications	<ul style="list-style-type: none">• Interventions with physical contact• Open 'C' or 'L' re-direction with use of one hand• Open 'C' or 'L' direction with guided compliance or use of two hands• Release Techniques• Finger• Choke• Wrist• Clothing• Bite• Hair (1 & 2 hand)• Headlock• Physical Escort• Physical Restraint (one arm, two arms, three-person standing, seated in chair)• Lift & Carry Technique• PRN Medications
Prohibited	Please review most current DD policy, licensure policy, regulations, and accreditation requirements (seclusion, prone restraint, corporal punishment, discipline by another individual, aversive conditioning, time out room use, mistreatment, floor restraints, and seated restraints).	

RESTRICTIVE PROCEDURES

The following procedures should only be requested by the interdisciplinary team after alternative, lesser restrictive measures have been exhausted. The individual and their guardian need to consent, through the team process, to these measures **prior to** HRC/BSC approval. Restrictive procedures should only be requested only when:

1. The safety and well-being of the individual served is jeopardized,
2. The safety and well-being of those around him/her is jeopardized, or,
3. Major property destruction will more than likely occur if the procedure was not implemented.

MONITORING DEVICES: Refers to devices used to identify the whereabouts of an individual. Examples of this are, but not limited to: chimes on the door, a monitor in a room, bed and/or chair alarms, cameras in the home used to monitor for health and safety purposes, etc. This procedure requires approval from HRC, and in some cases, BSC, where it is being used to monitor behavioral issues. ****NOTE: Considerations for the use of monitoring devices: how long is the monitoring on; shouldn't be visible for all to see; how is privacy addressed; person's reaction to the monitoring; specific conditions in place for the use; should not be used to replace staffing; monitoring location; health and safety concerns; risk of not using; other least restrictive solutions; monitoring in bedrooms should be limited in use (e.g. for serious medical conditions); informed consent all off those impacted is obtained.**

LIMITED ACCESS: Relates to the rights violation issues when rights infringements are imposed on the individual. Examples of this are, but not limited to: money monitoring, locking of items/areas within the home to prevent injury to self and others, medications locked, locked areas of the home, etc. This procedure requires approval from HRC, and in some cases, BSC.

PHYSICAL TRANSPORT: Manually transporting a person from one environment in which the individual is exhibiting behavior that is potentially dangerous to themselves or others, to an environment where reward for desired behavior is more likely to occur (increased staff support, less attention for negative behavior, increased redirection, increased reward opportunities). The procedure allows for the use of the hierarchy as least restrictive measures should be tried as indicated as follows:

Therapeutic Intervention Hierarchy	Therapeutic Response Hierarchy
1. Verbal prompt	1. Intervention with physical contact
2. Shadow guidance	2. Open 'C' redirection with use of one hand
3. Basic come-along	3. Open 'C' redirection with guided compliance/use of 2 hands
4. Two-hand come-along	4. One-arm support and restraint
5. One-person physical transport (underarm hook)	5. Two-arm support and restraint
6. Two-person physical transport	6. Two-arm restraint with second staff assist
	7. Lifting technique, and
	8. Lift and Carry technique
<i>The procedures listed above require approval from the Human Rights Committee & the Behavior Support Committee.</i>	

PHYSICAL RESTRAINT: A manual procedure of holding which is intended to restrict the movement or normal functioning of a portion of the individual's body. This method is only to be used when a person is exhibiting behavior which is potentially dangerous to themselves or others, or major property destruction is occurring. This includes the following:

Therapeutic Intervention Hierarchy	Therapeutic Response Hierarchy
<ol style="list-style-type: none"> 1. Physical hold 2. Basket hold restraint 3. Physical lifts 	<ol style="list-style-type: none"> 1. One-arm support and restraint 2. Two-arm support and restraint 3. One-arm restraint with second staff assist 4. Third staff assist 5. Lifting technique 6. Lift and Carry technique 7. Side body support and restraint
<i>The procedures listed above require approval from the Human Rights Committee & Behavior Support Committee.</i>	

If the individual drops to the ground/floor during a physical restraint, the team member should ensure monitoring of the individual from a safe distance to allow for calming. If the individual displays behavior that may or will cause safety concerns, reassess the situation and follow the hierarchy as needed to ensure the safety of self, others, and to prevent major property destruction. If during the incident where the individual has dropped to the ground/floor and the restraint has been released, the individual displays self-injurious behavior (bangs his/her head or extremities on the floor, or harms self by displaying any other self-injurious behavior, etc.), a physical hold to stabilize only the body part that is being subjected to injury will be held following the approved hierarchy to prevent injury. ****NOTE: Provider Agencies have the flexibility to continue to use the basket hold if they are using Therapeutic Responses for their other agency approved procedures.**

PHYSICAL RELEASE TECHNIQUES: are used to stabilize and allow or enable another person to release themselves when an individual is directly holding onto or grabbing their body or clothing.

Therapeutic Intervention Hierarchy	Therapeutic Response Hierarchy
<ol style="list-style-type: none"> 1. Finger peel 2. Finger release 3. Choke release 4. Wrist release 5. Clothing release 6. Bite release 7. Hair release, and 8. Headlock release 	<ol style="list-style-type: none"> 1. Finger release 2. Wrist release 3. Clothing release 4. Bite release 5. Hair pull release 6. Choke release, and 7. Headlock release
<i>The procedures listed above require approval from the Human Rights Committee & Behavior Support Committee.</i>	

DEVICES USED TO LIMIT MOVEMENT: A procedure used to limit movement of an individual to assist in ensuring his/her health and safety and should not to be used for behavioral control. These devices are used to aid the individual from limiting his/her movement due to the individual's inability to control movement for him/herself, which can pose a potential injury or safety issue. This may include, but are not limited to: devices used to control spasticity, bedrails to prevent someone from falling out of bed,

stabilization devices where the individual is not able to hold up a body part (i.e., head), seatbelt on a wheelchair, etc. If a person cannot hold themselves up or control their movements and the devices are used for positioning, HRC approval may not be needed. However, if the devices are used to keep a person from moving, or the person seems to be resisting or releasing the straps, it would require approval from HRC. Bed rails must go through HRC, there must be an assessment prior to use, and documentation of other least restrictive techniques tried. ****NOTE: Devices of this nature should never be used for behavioral control as this would then be considered a prohibited procedure as noted in the section of the policy under 'mechanical restraint.' Safety is the main concern with the use of these devices.**

INVOLUNTARY REMOVAL TO A CALMING AREA: a procedure that results in removal from an environment where behavior is occurring to a neutral environment where the person can “calm” themselves and be able to voluntarily return to the environment by using skills that are adaptive and socially productive. This may range from having an individual move away from the activity, to leaving the room altogether.

Involuntary removal purposes must indicate that the individual is exhibiting behavior which is potentially dangerous to themselves or others or is causing major property destruction. In cases where this may occur, the individual would be in a highly agitated state of mind where he/she would not be able to remove themselves. The individual's disorganization may be worsened by the particular setting in which they are unable to remove themselves. Thus, a separate area that is free from distractions and less stimulation would allow the individual to “calm.” The individual should be able to move about the area freely and should never be blocked or door locked/held closed to prevent from leaving the area. The hierarchy as noted in the Physical Transport definition should be followed when moving someone to a calming area. This procedure requires approval from HRC and BSC. CQL and Title XIX regulations may also address the use of a calming area. ****NOTE: DD Division policy prohibits seclusion which is defined as, “the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving.**

MEDICATIONS USED TO ASSIST IN BEHAVIORAL CONCERNS: Medication should not be used as punishment, for the convenience of staff, as a substitute for a program, or in quantities that interfere with an individual's developmental program. The team must identify the targeted behavior and must complete a thorough Functional Behavior Assessment or Functional Analysis which identifies a plan of action to eventually fade the use of medication(s) by assisting the individual to learn a more socially adaptive replacement behavior. The team should identify the side effects, risks versus risks, dosage ranges, and ensure that the recommended screenings (AIMS, TD) or bloodwork are completed regularly. The use of PRN medication used to calm an individual who is becoming agitated or aggressive towards others, is considered in this restrictive procedure. All PRN medication(s) used for this purpose should come through and be approved by HRC and BSC, regardless of diagnosis, prior to its use. The medication may be used as long as the aforementioned criteria has been defined.

MEDICAL RESTRAINT: Medications or general anesthetics when routinely used to control the behavior of an individual during a necessary medical or dental procedure for which the general population would not receive medications or general anesthetics for the same procedure(s). Requirements for this procedure are: list of current medication(s) and potential side effects, in addition to justification of the use of the medication. This procedure requires approval from HRC and BSC.

MEDICATIONS USED TO TREAT PSYCHIATRIC SYMPTOM(S): Utilization of psychotropic medication(s) should have a reviewing mechanism to assure the effectiveness of the medication(s). The following safeguards/assurances must be in place for medication usage for psychiatric illnesses/symptoms:

- The prescribed medication should match the psychiatric diagnosis or accompanying symptoms of the diagnosis and the team should have a clear understanding of the usage of the medication(s).
- A thorough, constant review of the following: side effects, risks versus risks, dosage ranges, screenings (AIMS, TD), monitor and complete blood levels accordingly, and the short-term/long-term usage of the medication(s).
- The prescribing physician is reviewing the medication(s) for effectiveness.
- If three or more psychotropic medications are prescribed, an independent review of the medications should be completed each time the medication regimen changes.
- The individual's team is actively monitoring and reviewing these areas and assuring that risks are minimal. Each Provider Agency has set forth the timelines within their policy for their formal review process as well as the team of people who review the medication(s) (i.e., the Program Coordinator (PC), QDDP, Case Manager (CM), or Behavior Analyst (BA)).
- A medication may be used as long as the aforementioned criteria has been defined and WOULD NOT require due process through Committees. If a psychotropic medication is used WITHOUT a corresponding psychiatric diagnosis, it should go through due process as a restriction and requires approval from HRC and BSC prior to its use.

SEARCH/SEIZURE: A procedure used to remove an item from an individual that does not belong to them or removal of a possession to prevent harm. The procedure would be used in situations where placement may be jeopardized, or their health becomes a factor (i.e., diabetes). The search would involve a verbal or gestural prompt for the person to show you the missing item; or a visual viewing of the person; or "patting the individual down" if an item is missing or is suspected to have been taken by the individual. If an item is found, ask the person to return it to its origination (if taken from a public site), staff, or peer. If the person is unwilling to return the item, a seizure can be implemented for the item to be removed from the individual. Physical intervention may be needed to remove the item; however, fading of the intervention should occur when the individual returns the item, or tells you they will return the item, or resistance has decreased during the seizure. This procedure requires approval from HRC and BSC.

If at any time the Committee(s) does not approve a procedure, the agency/team for which represents the individual will reconvene the team to address other alternatives. If needed, the Provider Agency may seek a third-party review, in which the party is unrelated to the individual, to ultimately assure that all risks and benefits of the procedure have been discussed prior to making the decision to proceed with the procedure. Possible third-party entities may include, but are not limited to: physician(s), pharmacy, Protection & Advocacy, etc. The Provider Agency would be responsible for all tracking, monitoring, and review of the restrictive procedure. The procedure needs to follow the same requirements for review and needs to be brought back to the Human Rights Committee and, where indicated, the Behavior Support Committee.

EMERGENCY PROCEDURES

EMERGENCY PROCEDURES are to be used only when an individual's behavior becomes severely aggressive or so destructive that the behavior places the individual or others in imminent danger of physical harm, or major property destruction is likely to occur, when those reasonably could not have been anticipated. The behavior is at a point where the team member is no longer able to respond to the situation effectively/safely. The situation is one in which: 1) the individual is endangering him/herself and/or others and not just a situation of individual noncompliance; or 2) significant property damage is occurring or in real danger of occurring.

The Provider Agencies have implemented the **IGNORE-REDIRECT-INTERRUPT-REWARD** paradigm during emergency procedures. The **IGNORE-REDIRECT-INTERRUPT-REWARD** teaching paradigm stresses the use of all four concurrently to diffuse an unforeseen, severely aggressive, or destructive behavior.

In order to monitor and control the use of emergency procedures, the staff implementing the procedure should be responsible for completing a General Event Report (GER)/incident report which is reviewed by the agency's Program Coordinator/QDDP, with copies forwarded to other appropriate agency personnel (i.e., Behavior Analyst, Nurse, Social Worker, Risk Management Committee, etc.). An agency representative (Program Coordinator, Behavior Analyst, QDDP, etc.) has the responsibility of notifying the agency's internal Protective Service Committee (PSC)/Risk Management Committee (RMC)/Quality Assurance (QA) in writing within 10 working days of the emergency procedure. Only three emergency procedures should be used in a six-month time frame, at which time the interdisciplinary team needs to meet to discuss the area of concern. The team may need to meet sooner based on the severity of the incident(s).

Ignore: giving no attention to a specific behavior.

Redirect: gestural, verbal, or physical cue to participate in a desired activity.

Interrupt: manual methods which are intended to restrict movement or normal functioning of a portion of an individual's body (physical holding) in the environment where the severely aggressive or destructive behavior occurred.

Reward: verbal or tangible reward delivered to a person when they are engaging in a desired activity or behavior. The reward can be delivered intermittently when engaging in any type of behavior in which the reward may significantly lessen the undesirable behavior.

The PSC/RMC/QA should review all emergency procedures brought before the Committee(s). The review process should be done to assure that the individual's rights are protected and that unnecessary uses of procedures are not occurring. This review process will be done on behalf of the individual served. If questions arise, the RMC/QA can request further information from the QDDP/PC in writing. The Committee(s) should then review this at their next scheduled meeting.

EMERGENCY PROCEDURES are used to prevent an individual from inflicting bodily harm and should not be repeated more than three times within six months. The interdisciplinary team should meet within 10 working days of the third time of utilization of the procedure to develop a plan of action. If the plan contains a restrictive procedure, it should be presented to the Human Rights Committee and if needed, the Behavior Support Committee, by the date indicated on the **emergency approval form**. If the emergency situation continues after physical intervention is used or when physical intervention is not

appropriate, the staff member should call Emergency Services (9-1-1) for assistance. Once the individual desists from dangerous behavior, an emergency no longer exists!

EMERGENCY EVACUATION: In the event the fire alarm sounds, or some other event were to occur requiring immediate evacuation of the building, all programs should be stopped with the safe evacuation of the building being the priority.

PHYSICAL RESTRAINT: A manual procedure of holding which is intended to restrict the movement or normal functioning of a portion of the individual's body. This method should only be used when a person is exhibiting behavior which is potentially dangerous to themselves or to others, or major property destruction is occurring.

Therapeutic Intervention Hierarchy	Therapeutic Responses Hierarchy
<ol style="list-style-type: none"> 1. Physical hold; 2. Baskethold restraint; 3. Physical lifts 	<ol style="list-style-type: none"> 1. One-arm support and restraint; 2. Two-arm support and restraint; 3. One-arm restraint with second staff assist; 4. Third staff assist; 5. Lifting technique; 6. Lift and carry technique; 7. Side body support and restraint

PHYSICAL RELEASE TECHNIQUES are used to stabilize and allow or enable another person to release themselves when an individual is directly holding onto or grabbing their body or clothing.

Therapeutic Intervention Hierarchy	Therapeutic Responses Hierarchy
<ol style="list-style-type: none"> 1. Finger peel; 2. Finger release; 3. Choke release; 4. Wrist release; 5. Clothing release; 6. Bite release; 7. Hair release; 8. Headlock release. 	<ol style="list-style-type: none"> 1. Finger release; 2. Wrist release; 3. Clothing release; 4. Bite release; 5. Hair pull release; 6. Choke release; 7. Headlock release

PHYSICAL TRANSPORT: Manually transporting a person from one environment in which the individual is exhibiting behavior that is potentially dangerous to themselves or others to an environment where reward for desired behavior is more likely to occur (increased staff support, less attention for negative behavior, increased redirection, increased reward opportunities). This procedure allows for the use of the hierarchy as least restrictive measures should be tried if the intervention to the behavior allows this.

Therapeutic Intervention Hierarchy	Therapeutic Responses Hierarchy
<ol style="list-style-type: none"> 1. Verbal prompt; 2. Shadow guidance; 3. Basic come along; 4. Two-hand come along; 5. One-person physical transport (underarm hook); 6. Two-person physical transport 	<ol style="list-style-type: none"> 1. Intervention with physical contact; 2. Open 'C' redirection with guided compliance/use of two hands; 3. Open 'C' redirection with guided compliance/use of two hands; 4. One-arm support and restraint 5. Two-arm support and restraint 6. Two-arm restraint with second staff assist; 7. Lifting Technique; 8. Lift and Carry Technique

REFERENCE TO DD POLICY

All incidents involving rights violations and/or restrictions must be reported to the Human Rights Committee. Providers who have an internal Protective Service Review Committee or Quality Assurance Team that reviews all incident reports utilizing the Reporting Determination Guidelines have the option to report to the HRC only those incidents in which there are rights violations and/or restrictions as part of the allegation. If the incident does not involve a rights violation and/or restriction, the Provider is not required to report the incident to the HRC. The Protective Service Review Committee/Quality Assurance Team will be responsible to review the incident report according to the requirements of this policy.

Providers must document whether the incident was reported to the Human Rights Committee, and if the incident was reported to the HRC, the date of notification. This can be accomplished by noting it on the Investigative Action Level Checklist or documenting in the internal investigation report, also known as a GER.

The Human Rights Committee may, upon request, have access to provide reports, investigations, and findings related to the incidents of abuse, neglect, and exploitation if, in the course of their reviews, they have reason to believe there may be patterns of rights violations or systemic issues that need to be examined and analyzed. Provider Agencies, Protection & Advocacy, and DD Program Management may also ask the HRC to review. If necessary, an emergency approval must be obtained when the Committee is not scheduled to meet, and it is essential that the plan must be implemented to ensure the individual's health and safety. Plans cannot be implemented until all three levels have been approved (Individual, Legal Decision Maker, Behavior Support Committee, and Human Rights Committee).

APPENDIX

Title XIX Regulations for ICF/IDD

Licensure

Laws and Regulations

CQL Personal Outcome Measures

DD Bill of Rights

Sample Rights Assessment

*HRC/BSC Information Gathering Form

*HRC/BSC Restriction/Approval Form

*Behavior Support/Human Rights Questionnaire

*Peer Review of Behavioral Supports (PRoBeS-2.0)

Functional Behavior Assessment Interview

Functional Behavior Assessment Template

Positive Behavior Supports Staff Training Checklist

Physical Intervention Techniques Staff Training Checklist

Quick Reference: Emergency Procedure Prompting Hierarchy

Glossary: Terms and Definitions

*****NOTE: These are sample materials obtained from multiple sources that may or may not be applicable, or useful, to each Provider Agency. They are not endorsed by the authors of this Toolkit.***

TITLE XIX REGULATIONS FOR ICF/ID

W125

(Rev. 135, Issues: 02-27-15, Effective: 04-27-15, Implementation: 02-27-15)

§483.420(a)(3) Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process;

Guidance §483.420(a)(3)

To the extent that a client is able, choices are made on his/her own. Each client has autonomy of decision making and choice.

They are free to move about without limitations imposed due to staff preferences or staff convenience.

Clients are not restricted without due cause or due process.

To the extent that the client is able to make decisions for him or herself, it is inappropriate to delegate the person's right to others (e.g., parents, family members, etc.).

The facility has an obligation to assure client health and safety and must balance that obligation with the rights of clients. If the facility has implemented a restriction, the following should be in place:

- An assessment supporting the need for the restriction;
- An individualized behavior plan to reduce the need for the restriction has been developed and implemented;
- A written informed consent for the behavior plan which includes the restriction;
- Approval of the Specially Constituted Committee; and
- Monitoring by the Committee of the progress of the training program, designed to reduce and eventually eliminate the restriction.

Clients, families, and legal guardians have the right to register a complaint with the facility and the State Survey Agency. If so, the facility must respond promptly and appropriately. The facility must ensure protection of the client from any form of reprisal or intimidation as a result of a complaint or grievance reported by the client, family, or legal guardian.

Issues involving the exercise of constitutional rights such as voting should be addressed as a component of the IPP when the Interdisciplinary Team (IDT) determines a need for training.

Clients who have been adjudged to need guardianship or have been assessed as needing assistance to advocate for themselves should receive assistance or support so they may exercise their rights as citizens of the United States.

W261

(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)

§483.440(f)(3) The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility to -

Guidance §483.440(f)(3)

The facility must have a specially constituted committee whose primary function is to proactively protect client rights by monitoring facility practices and programs. The purpose of the committee is to assure that each client's rights are protected utilizing a group of both internal staff and *external participants who have no vested interest in the facility as well as clients as appropriate*. There should be evidence that the committee members have been trained annually on the rights of the clients, what constitutes a restriction of a right and the difference between punishment and training.

Depending on size, complexity and available resources, the ICF/IID may establish more than one specially constituted committee. However, each committee must contain the required membership and participate regularly and perform the functions of the committee according to the requirements. Participation on the specially constituted committee(s) must be in real time allowing all membership to speak and discuss in an interactive mode.

The regulation does not specify the professional credentials of the "qualified persons" (who have either experience or training in contemporary practices to change inappropriate client behavior). There is no requirement that any specific discipline, such as nurse, physician or pharmacist be a member of the committee.

The intent of including "persons with no ownership or controlling interest" on the committee is to assure that, in addition to having no financial interest in the facility, at least one member of each constituted committee is an impartial outsider in that he/she would not have an "interest" represented by any other of the required members or the facility itself. Staff and consultants employed by the facility or at another facility under the same governing body, cannot fulfill the role of person with no ownership or controlling interest.

Although occasional absences from committee meetings are understandable, patterns of absence by the required membership of the committee is not acceptable. At least a quorum of committee members (as defined by the facility) must review, approve and monitor the programs which involve risk to client rights and protections and that quorum must include one person from each of the required categories.

W262

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(f)(3)(i) Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.

Guidance §483.440(f)(3)(i)

Any program that utilizes restrictive or intrusive techniques must be reviewed and approved by the specially constituted committee prior to implementation. This includes, but is not limited to:

- restraints;
- drugs to manage behavior;
- restrictions on community access;
- contingent denial of any right; or
- restrictions of materials or locations in the home.

The committee should ensure that consequences within a written behavior management program do not violate the client's rights.

There is no requirement for the committee to evaluate whether the proposed program is consistent with current practices in the field. Documentation should verify that the specially constituted committee considered factors, such as whether less intrusive methods have been attempted, whether the severity of behavior outweighs the risks of the proposed program and whether replacement behaviors are included within the plan.

Any revision to a behavior plan that increases the level of intrusiveness must be re-reviewed by the specially constituted committee. The committee need not reapprove a program when revisions are made in accordance with the approved plan. For example, if the physician changes the dosage of a medication in accordance with the drug treatment component of the active treatment plan to which the legally authorized person has given consent and which has already been approved by the committee, then there is no need for the committee or the legally authorized person to reapprove the plan. Generally, this would also apply if the medication was changed to another within the same therapeutic class or family.

W263

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(f)(3)(ii) Ensure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian; and

Guidance §483.440(f)(3)(ii)

The committee must ensure that written informed consent must be obtained prior to implementation of any restrictive or intrusive program. In the event of an emergency, the facility may obtain a verbal consent, which must be authenticated in writing as soon as possible and subsequently submitted to the committee as verification.

The consent is required for the entire behavior management program not just the specific restrictive technique.

Consent is informed when the person giving consent is fully aware of the:

- specific treatment;
- reason for treatment or procedure;
- the attendant risks vs. benefits;
- alternatives;
- right to refuse; and
- the consequences associated with consent or refusal of the program.

Informed consent must be in writing and must be specific to the program and restrictive practice and reflect a specific time frame. Blanket consents are not allowed. In the case of unplanned events such as assault and property destruction requiring immediate action, verbal consent may be obtained. However, it should be authenticated in writing as soon as reasonably possible (within 30 days).

For clients up to the age of 18, their parent or legally appointed guardian must give consent for him or her. At the age of 18, however, clients become adults and are assumed to be competent unless otherwise determined by a court.

For clients who are adults and have not been adjudicated incompetent and have not been assigned a legal guardian who may not fully understand the consequences of the program, informed consent for use of restrictive programs, practices or procedures should be obtained from a person or an entity in accordance with state law, to act as the representative or advocate of the client's interests.

The specially constituted committee must ensure that the informed and voluntary consent of the client, parent of a minor, legal guardian, or the person or organization designated by the state is obtained prior to each of the following circumstances:

- The involvement of the client in research activities; or
- Implementation of programs or practices that could abridge or involve risks to client protections or rights.

W264

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(f)(3)(iii) Review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.

Guidance §483.440(f)(3)(iii)

The committee has been made aware of and reviewed:

- facility policies and procedures;
- facility services;
- programs; and
- practices which may restrict or violate the rights of client.

The committee has established and uses a mechanism for monitoring clients' rights issues and informs the governing body of any issues of concern in a timely manner. This process is at the discretion of the committee. There is no requirement for periodic review of the policies by the committee.

The function of the committee is not limited to the review, approval and monitoring of restrictive behavior management practices. Examples of issues involving client rights that might be reviewed by the committee, in addition to behavior management, include, but are not limited to:

1. Research proposals involving clients;
2. Abuse, neglect and mistreatment of clients;
3. Allegations dealing with theft of a client's personal property or funds;
4. Damage to a client's goods or denial of other client rights;
5. Client grievances;
6. Visitation procedures;
7. Guardianship/advocacy issues;
8. Rights training programs;
9. Confidentiality issues;
10. Advance directives/DNR orders;
11. Practices which restrict clients (e.g., locked doors, fenced in yards); and
12. Video monitoring.

LICENSURE

All DD licensed providers within the state, are required to comply with the regulations and accreditation standards regarding Human Rights Committees.

As part of licensure, all agencies must have policies and procedures that outline their agency's commitment to the protection and promotion of client rights.

ND Administrative Code 75-04-01-20 (m) states:

1. Applicants shall submit, in a manner prescribed by the department, evidence that policies and procedures approved by the governing body are written and implemented in a manner which:
 - m. Assures the existence and operation of both behavior management and human rights committees.

DD Policy outlines the training requirements for licensed DD Providers relative to client rights.

LAWS AND REGULATIONS

Laws and regulations regarding seclusion and restraint are referenced at both the state and federal level as well as within North Dakota Developmental Disabilities Division (DDD) policies.

State statutes pertinent to seclusion and/or restraint include NDCC 24-01.2-01 (3), NDCC 25-01.2-02, NDCC 25-01.2-08, NDCC 25-01.2-09, and NDCC 25-01.2-10 in chapter NDCC 25-01.2 on Developmental Disabilities and NDCC 25-01.3-01 (1) and (14), which pertains to definitions of abuse and neglect in chapter NDCC 25-01.3 of the Committee on Protection & Advocacy.

Federal statutes include 42 U.S.C. § 15009 entitled Rights of Individuals with Developmental Disabilities and 42 U.S.C. § 290jj entitled Requirements Relating to the Rights of Residents of Certain Non-medical, Community-based Facilities for Children and Youth. Federal regulations include 42 C.F.R. 483.420 entitled Condition of participation: Client protections, 42 C.F.R. 483.440 entitled Condition of participation: Active treatment services, 42 C.F.R. § 483.450 entitled Condition of participation: Client behavior and facility practices, 45 C.F.R. § 1386.19 entitled State System for Protection and Advocacy of the Rights of Individuals with Developmental Disabilities.

Policies adopted and promulgated by the ND DHS/DDD can be found on the DHS website: ND DHS bookshelf at: <http://www.nd.gov/dhs/policymanuals/816/816.htm>.

CQL PERSONAL OUTCOME MEASURES

My Human Security:

Non-negotiable human and civil rights.

1. People are safe.
2. People are free from abuse and neglect.
3. People have the best possible health.
4. People experience continuity and security.
5. People exercise rights.
6. People are treated fairly.
7. People are respected.

My Community:

Access to be in, a part of, and with, community.

8. People use their environments.
9. People live in integrated environments.
10. People interact with other members of the community.
11. People participate in the life of the community.

My Relationships:

Social support, intimacy, familiarity, and belonging.

12. People are connected to natural support networks.
13. People have friends.
14. People have intimate relationships.
15. People decide when to share personal information.
16. People perform different social roles.

My Choices:

Decisions about ones' life and community.

17. People choose where and with whom they live.
18. People choose where they work.
19. People choose services.

My Goals:

Aims for the future.

20. People choose personal goals.
21. People realize personal goals.

DD BILL OF RIGHTS

NDCC 25-01.2 DD Bill of Rights

A person with a developmental disability has constitutional, civil, and legal rights which include, but are not limited to the following:

The RIGHT to:

1. Treatment, services, and habilitation in the least restrictive, appropriate setting.
2. Be presumed competent until a court of law determines otherwise.
3. Vote.
4. Free exercise of religion.
5. Free association, including association with the opposite sex.
6. Confidential handling of person and medical records.
7. Receive, possess, use, and have secure lawful personal property.
8. Reasonable access to mail, telephone, and visitors.
9. Be paid the value of work performed, to freely deposit earnings and other funds, and to retain all accumulated funds, including wages earned from the service provider.
10. Approve or disapprove service providers as payee of the person's social security, pension, annuity trust fund, or any other direct payment or assistance.
11. Receive appropriate and adequate medical and dental care if living in an institution or residential facility.
12. Be free from chemical restraint and to receive only properly prescribed and promptly recorded drugs and medications.
13. Be free from corporal punishment.
14. Be free from isolation and physical restraints, except in emergencies (defined as imminent danger of causing harm to oneself or others).
15. Be free from psychosurgery, sterilization, and medical research, if receiving services at an institution or community facility.
16. Be free from shock therapy.
17. Be checked at least once every 30 minutes when properly placed in restraints or isolated for program purposes.
18. An adequate and sufficient diet planned by a dietician, if residing in an institution or residential facility.
19. A free and appropriate public education in the least restrictive, appropriate public-school setting or vocational setting, if between the ages of 3 through 21.
20. An individual habilitation or education plan within 30 days after admission to a program, to be reviewed at least annually.
21. Refuse treatment unless required to prevent serious harm to one's self or others.
22. Enforce these rights in a court of law or appropriate administrative proceedings.

SAMPLE RIGHTS ASSESSMENT

United Nations Declaration of Human Rights Assessment

(Sample document for use)

Document was obtained from website: www.ohchr.org

Individual Name (please print) _____

Guardianship Status: ☐ Unregulated ☐ Full ☐ Limited

If Guardianship Status is Limited, state areas of guardianship:

☐ Financial ☐ Medical ☐ Legal ☐ Residential/Vocational

Other areas limited within the guardianship: _____

☐ Vote ☐ Marital Status ☐ Testify ☐ Driver's License ☐ Other: _____

Is the level of guardianship the least restricted and most appropriate: ☐ Yes ☐ No

If not, what is the plan to change this? _____

Would a Guardian be appropriate? ☐ Yes ☐ No

If yes, what areas and why? _____

☐ Financial ☐ Medical ☐ Legal ☐ Residential/Vocational

Representative Payee: ☐ Yes ☐ No

If yes, who is designated? _____

Why is a Payee needed? _____

Is money restricted? ☐ Yes ☐ No

If yes, explain the **RESTRICTION**: _____

Advocacy Services: ☐ Yes ☐ No

If yes, explain: _____

Is the individual able to make decisions based on preferences and considering the alternatives, options, solutions, and consequences of the decisions? ☐ Yes ☐ No

If no, explain areas of needed assistance: _____

Rights Limitations: ☐ Yes ☐ No

If yes, explain: _____

Has Due Process been explained to the individual? ☐ Yes ☐ No

Is there a plan to face and/or eliminate the restriction? ☐ Yes ☐ No

Does the individual understand the process of the Human Rights/Behavior Support Committees?

☐ Yes ☐ No

Does the individual want to attend the HRC/BSC review of their restrictions? ☐ Yes ☐ No

Is there a support plan (Objective/Guidelines): ☐ Yes ☐ No

Privacy Limitations: ☐ Yes ☐ No

If yes, explain: _____

Does the individual have limited access to the following? Check all that apply.

- | | | |
|--|--|--|
| <input type="checkbox"/> Freedom of movement | <input type="checkbox"/> Phone access | <input type="checkbox"/> Locked doors |
| <input type="checkbox"/> Supervision limits | <input type="checkbox"/> Monitors | <input type="checkbox"/> Limited access |
| <input type="checkbox"/> Accessing/sharing records | <input type="checkbox"/> Association with others | <input type="checkbox"/> Mail |
| <input type="checkbox"/> Access to personal items | <input type="checkbox"/> Personal Space/Own Room | <input type="checkbox"/> Other, explain: _____ |

When children are born, they are free, and each should be treated in the same way. They have reason and conscience and should act towards one another in a friendly manner:

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

Everyone can claim the following rights, despite a different sex, a different skin color, speaking a different language, thinking different things; believing in another religion; owning more or less; being born in another social group; coming from another country. It also makes no difference whether the country you live in is independent of not.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

You have the right to live, and to live in freedom and safety.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

Nobody has the right to treat you as his or her slave and you should not make anyone your slave.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

Nobody has the right to torture you.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

You should be legally protected in the same way everywhere, and like everyone else.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

The law is the same for everyone; it should be applied in the same way to all.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

You should be able to ask for legal help when the rights your country grants you are not respected.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

Nobody has the right to put you in prison, to keep you there, or to send you away from your country unjustly, or without a good reason.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

If you must go on trial this should be done in public. The people who try you should not let themselves be influenced by others.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

You should be considered innocent until it can be proved that you are guilty. If you are accused of a crime, you should always have the right to defend yourself. Nobody has the right to condemn you and punish you for something you have not done.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

You have the right to ask to be protected if someone tries to harm your good name, enter your house, open your letters, or bother you or your family without a good reason.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

You have the right to come and go as you wish within your country. You have the right to leave your country to go to another one; and you should be able to return to your country if you want.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

If someone hurts you, you have the right to go to another country and ask it to protect you. You lose this right if you have killed someone and if you yourself do not respect what is written here.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

You have the right to belong to a country and nobody can prevent you, without a good reason, from belonging to another country if you wish.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

As soon as a person is legally entitled, he or she has the right to marry and have a family. Neither the color of your skin, nor the country you come from nor your religion should be impediments to doing this. Men and women have the same rights when they are married and also when they are separated. Nobody should force a person to marry. The Government of your country should protect your family and its members.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

You have the right to think what you want, and to say what you like, and nobody should forbid you from doing so. You should be able to share your ideas – also with people from any other country.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

You have the right to organize peaceful meetings or to take part in meetings in a peaceful way. It is wrong to force someone to belong to a group.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

You have the right to take part in your country's political affairs either by belonging to the Government yourself or by choosing politicians who have the same ideas as you. Governments should be voted for regularly and voting should be secret. You should get a vote and all votes should be equal. You also have the same right to join the public service as anyone else.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

The society in which you live should help you to develop and to make the most of all the advantages (culture, work, social welfare) that are offered to you and to all the men and women in your country.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

You have the right to work, to be free to choose your work, and to get salary that allows you to live and support your family. If a man and a woman do the same work, they should get the same pay. All people who work have the right to join together to defend themselves.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

Each workday should not be too long since everyone has the right to rest and should be able to take regular paid holidays.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

You have the right to have whatever you need so that you and your family: do not fall ill; do not go hungry; have clothes and a house; and are helped if you are out of work, if you are ill, if you are old, if your wife or husband is dead, or if you do not earn a living for any other reason you cannot help. Both a mother who is going to have a baby and her baby should get special help. All children have the same rights, whether or not the mother is married.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

You have the right to go to school and everyone should go to school. Primary schooling should be free. You should be able to learn a profession or continue your studies as far as you wish. At school, you should be able to develop all your talents and you should be taught to get on with others, whatever their race, their religion, or the country they came from. Your parents have the right to choose how and what you will be taught at school.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

You have the right to share in your community's arts and sciences, and in any good they do. Your works as an artist, a writer, or a scientist should be protected, and you should be able to benefit from them.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

To make sure that your rights will be respected, there must be an “order” that can protect them. This “order” should be local and worldwide.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

You have duties towards the community within which your personality can fully develop. The law should guarantee human rights. It should allow everyone to respect others and to be respected.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

No society and no human being in any part of the world should act in such a way as to destroy the rights that you have just been reading about.

☐ Exercised ☐ Exercised with Assistance ☐ Not Exercised

If exercised with assistance or not exercised, please explain:

****The rights explained to you are your human rights. If you have a guardian, the guardianship papers will explain where your decision-making ability is limited. If your plan states limitations, these limitations must go before the Human Rights Committee to endure due process.**** The individual, guardian, if applicable, must acknowledge that they have been informed of their rights and are in agreement with what has been identified.

Individual's Name: _____ Date: _____

Guardian, if applicable: _____ Date: _____

Program Coordinator/Witness: _____ Date: _____

HRC/BSC SAMPLE FORM TO GATHER THE INFORMATION NEEDED FOR RECORD KEEPING

Client Name										
Region										
Provider(s)										
Residential Service(s)										
Day Program(s)										
FBA or FA Completed? (Date)										
Type of Restrictive Intervention or Restraint										
Was approval needed due to an Emergency Procedure?										
Individual/Legal Decision Maker Approval										
Date Approved by BSC										
Date Approved by HRC										
Program Implementation Date										
Next BSC Review										
Next HRC Committee Review										

HRC AND/OR BSC RESTRICTION APPROVAL/DENIAL FORM

(This form may be used by the HRC/BSC Committees. If another form is used, the content should be the same.)

Name: _____ **Date of Team Meeting:** _____

****Note: "ALL" RESTRICTIONS listed under Behavior Support Committee (BSC) must go through Human Rights Committee (HRC). Circle Y/N or N/A in each response.**

BSC Restrictions for Approval:	HRC Restrictions for Approval:
<u>BEHAVIOR SUPPORT REVIEW</u>	<u>HUMAN RIGHTS REVIEW</u>
Y N N/A 1. Have the RESTRICTIONS been identified?	Y N N/A 1. Have the RESTRICTIONS been identified?
Y N N/A 2. Is the function(s) of the person's behavior clearly defined (has a FUNCTIONAL BEHAVIOR ASSESSMENT or ANALYSIS been completed and when _____)?	Y N N/A 2. Recommendations from Behavior Support Committee reviewed?
Y N N/A 3. Have other factors been considered or ruled out as causes for the behavior (medical, environmental, psychiatric, etc.)?	Y N N/A 3. Is there an understanding and reasonable cause to justify the RESTRICTION(S) ?
Y N N/A 4. Are they based on an assessment of the function of the behavior, including, but not limited to, the communicative intent of behavior?	Y N N/A 4. Have other factors been considered or ruled out as causes for the behavior (medical, environmental, psychiatric, etc.)?
Y N N/A 5. Does the person have a Positive Behavior Support Plan, Behavior Plan, or a similar plan of strategies that involve Therapeutic Responses to help the person to be more successful?	Y N N/A 5. Is there a plan/mechanism in place that can help the individual to learn a new way to communicate the meaning of their behavior and/or learn a new skill?
Y N N/A 6. Is the use of psychoactive medication based on specific psychiatric diagnoses?	Y N N/A 6. Does the proposed plan incorporate the least restrictive approach, including a plan to fade and reinstate rights?
Y N N/A 7. Does the person take medication for behavior management (e.g., is the use of psychotropic medications for behavior support recognized as a chemical intervention and considered highly intrusive/restrictive)?	Y N N/A 7. Are formal behavior support plans implemented only after the team has ruled out physical and environmental issues contributing to a person's behavior?
Y N N/A 8. Are formal behavior support plans implemented only after the team has ruled out physical and environmental issues contributing to a person's behavior?	Y N N/A 8. Is there a plan/mechanism in place that can help the individual to learn a new way to communicate the meaning of their behavior?
Y N N/A 9. Do behavior support plans include teaching alternative communication and coping strategies?	Y N N/A 9. Are behavior intervention plans that include highly intrusive procedures or other restrictive techniques implemented only with the prior written, informed consent of the person or the person's legally authorized representative?
	Y N N/A 10. Is the committee convinced that the proposed plan is the least restrictive approach for this person?

Name: _____ Date of Team Meeting: _____

BEHAVIOR SUPPORT REVIEW

- Y N 10. Is there a plan/mechanism in place that
N/A can help the individual to learn a new way
to communicate the meaning of their
behavior?
- Y N 11. Does the proposed plan incorporate the
N/A least restrictive approach, including a plan
to fade, reinstate rights, and review of the
proposed restrictive procedures or
medications?
- Y N 12. Is there clear evidence that less
N/A restrictive/intrusive procedures have been
tried and not been effective?
- Y N 13. Are behavior intervention plans that
N/A include highly intrusive procedures or
other restrictive techniques implemented
only with the prior written, informed
consent of the person or the person's
legally authorized representative?
- Y N 14. Is the committee convinced that the
N/A proposed plan is the least restrictive
approach for this person?

BSC Comments and Recommendations:

Approved: ☐ Yes ☐ No Until Date: _____
☐ Not Approved (please provide rationale)
Resubmission Due Date: _____

BSC Chairperson Signature

HUMAN RIGHTS REVIEW

HRC Comments and Recommendations:

Approved: ☐ Yes ☐ No Until Date: _____
☐ Not Approved (please provide rationale)
Resubmission Due Date: _____

HRC Chairperson Signature

BEHAVIOR SUPPORT/HUMAN RIGHTS QUESTIONNAIRE FORM

This form is completed by the Program Coordinator/QDDP prior to presenting the information to the Human Rights or Behavior Support Committee.

Name: _____

DOB: _____

Date of Team Meeting: _____

Date of Review: _____

Procedure(s) requested:

1. What is/are the function(s) of the person's behavior (was a Functional Behavior Assessment or Functional Analysis completed)? Have other factors been considered (medical condition, environment, psychiatric diagnosis, etc.)?
2. How are the restrictive procedure(s) used and specifically address how the plan assists the person to learn a new way to communicate the meaning of their behavior is a socially acceptable manner? If the procedure involves medication(s), list the dosage range, the date prescribed, and how the medication (s) addresses the person's behavior.
3. List the alternatives tried prior to this/these procedure(s).
4. What side effects/collateral effects has the team considered in determining that the proposed plan is the most effective (risk of behavior versus risk of the procedure(s) (including environmental or medical concerns, other medication(s) taken, etc.)?
5. Explain the plan to fade/reduce/remove the procedure(s) or medication(s).
6. Explain how effective the medication(s) and/or restrictive procedure(s) are in addressing the person's behavior or in teaching the person a more productive way to communicate the meaning of their behavior. What is the short-term goal(s) for this person regarding the procedure(s) requested? What is the long-term goal(s)?

THE FUNCTIONAL BEHAVIOR ASSESSMENT (FBA), BEHAVIOR PLAN (BP), AND PROGRAM IMPLEMENTATION REVIEW (PR)

The Peer Review of Behavior Supports 2.0 (PRoBeS-2.0) RUBRICS GUIDE, SCORING FORM, and QUICK SCORE FORM-APPROVAL SHEET should be used together as an objective measure and scoring system for determining adequacy of behavioral assessment and planning. This tool may be used for Behavior Review Committees and/or Peer Review to identify essential features for effective Functional Behavior Assessment, Behavior Plan, and Program Implementation Review through the entire behavior intervention processes, according to industry standards in the field of applied behavior analysis (ABA).

The RUBRICS GUIDE is a detailed description with examples of how to score each component of the PRoBeS 2.0. This RUBRICS GUIDE can be used by novice peer reviewers to understand and learn each essential component of an FBA, BP, and PR to identify the necessary information to look for when reviewing an FBA and BP. Once reviewers become familiar with the use of this guide, they may no longer need to reference it as frequently, as the scoring measures will remain the same.

The SCORING FORM is a detailed scoring form where peer reviewers can make short-hand notes for each component as well as a brief description of each score indicated for each component. This form can be completed as a means to check for completeness. One SCORING FORM can be completed for each person a behavior review committee is reviewing. Scores will give teams a glimpse of the specific missing pieces of an FBA/BP that they need to complete or give them a sense of thoroughness of the plans they are bringing through the review process.

The QUICK SCORE FORM-APPROVAL SHEET can be used as the permanent documentation of scores given by a peer reviewer or behavior review committee for an individual person's FBA or BP being reviewed. This document also has space for committee members to grant approval for plan implementation as well as a time frame for approval.

QDDPs may also use this resource to gauge the adequacy and/or missing components of FBAs or BPs. They may also use these tools as a reference for the necessary information to gather when conducting assessments and drafting behavior plans.

The following PRoBes-2.0 documents are updated version dated 5-26-2020, and updates or revisions may be available.

Peer Review of Behavior Supports 2.0 (PRoBeS – 2.0) RUBRICS GUIDE
Functional Behavior Assessment (FBA), Behavior Plan (BP), and Progress Review (PR)

Component	0 = Not Addressed	1 = Partially Addressed	2 = Completely Addressed
Part 1: Functional Behavior Assessment (FBA) (Data Gathering and Hypothesis Development)			
<p>1. Interview is collected to have input from multiple people and/or sources to complete the functional behavior assessment interview. Could be:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Person served interview <input type="checkbox"/> Guardian interview <input type="checkbox"/> Caregiver/staff interview <input type="checkbox"/> Indirect measures (such as anecdotal notes, checklists, rating scales, etc.) 	<p>Unable to determine if input was collected from multiple people/sources; OR, FBA indicates that input was only gathered from one source.</p>	<p>Vague indication that input was collected from more than one person/source; details missing.</p> <p>Example:</p> <ul style="list-style-type: none"> • Checklist or list of names of people who participated in the FBA but no explanation of how they participated. • One source/person or list of names provided BUT No details gathered 	<p>Clear documentation that input was collected from more than one source with supporting details or the FBA/BP used a brief process aligned with a problem-solving format and indicated that at least 2 people participated in the meeting.</p> <p>Examples:</p> <ul style="list-style-type: none"> • Direct observation AND caregiver/staff rating scales indicated or checked. • Statements such as, "The staff and the guardian(s) were interviewed." • Two or more sources/people WITH supporting details relevant to the target behaviors. <p><i>*Note: If the FBA/BIP indicates that a brief process was used in alignment with a problem-solving meeting and at least two people were participants in the meeting, score this item as a 2.</i></p>
<p>2. Comprehensive File/Records Review has been conducted, summarized, and contains things such as:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Testing scores <input type="checkbox"/> Medical history including medications <input type="checkbox"/> Social and behavioral history <input type="checkbox"/> Strategies tried/previously implemented and the client's response/success/or lack of success with them 	<p>Unable to determine.</p>	<p>Half of the required information is present.</p>	<p>All of the required information is present and has been taken into consideration.</p>
<p>3. Problem behavior(s) are identified and operationally defined (easily observable and measurable). If more than one behavior is identified, it is clear which</p>	<p>No problem behavior(s) are identified; OR, Problem behaviors are identified and may be defined, but none of the behaviors identified is the focus of the FBA.</p>	<p>Behaviors are identified but definitions are ambiguous or subjective and do not provide enough information so that a person who is unfamiliar with the individual would</p>	<p>ALL identified problem behaviors are operationally defined (observable and measurable; can be seen, heard, counted), AND If more than one behavior is identified, it is clear</p>

Component	0 = Not Addressed	1 = Partially Addressed	2 = Completely Addressed
<p>behavior(s) are/will be the focus of the FBA.</p> <p><i>*Note: Behaviors do not need to be broken down into discrete units (e.g., pushes until other person is moved 1.5 meters/inches), but behaviors are defined so that anyone can determine when the behavior starts and stops.</i></p> <p><i>*Note: There needs to be a link between the behavior identified as the problem, the definition, and the behavior listed in the hypothesis to get full credit for this item.</i></p>		<p>agree, upon observation, that the behavior identified has started and stopped; OR, Problem behavior(s) are checked from a stock or dropdown list with no further definitions; OR, Definition of target behavior includes a list of multiple problem behavior names or multiple unique behaviors.</p> <p>Examples:</p> <ul style="list-style-type: none"> Ambiguous/subjective examples: <ul style="list-style-type: none"> Talks to peers Problem behaviors selected from list: <ul style="list-style-type: none"> Expressing anger Hostility Off-task Defiant Non-compliant List of multiple problem behaviors or grouping of unique behaviors under one category/vague overall title/one function: <ul style="list-style-type: none"> Inappropriate behaviors including pouting, crying, cursing, throwing objects at peers and staff; hitting, kicking pushing, leaving assigned area, & verbally threatening staff with bodily harm and property destruction 	<p>which behavior(s) are the focus of the assessment.</p> <p><i>*Note: If the FBA only identifies one problem behavior the problem behavior is clearly defined and is the focus of the FBA, score '2'.</i></p> <p>Examples:</p> <ul style="list-style-type: none"> Talks to peers without permission during independent work tasks. Disruption is defined as "hitting, kicking, and punching". Inappropriate behavior definition: Individual shouts negative comments to staff and peers which can escalate to (a) cussing at peers/adults, (b) throwing objects toward peers/adults; (c) getting up from assigned area and leaving the room while shouting out verbal threats. Shouts out curse words at staff Off task is defined as "playing with pencil, looking around the room, etc." Not starting work is defined as "looks around the room at peers, talks to peers sitting close to individual about topics unrelated to task, or turns head toward window and remains in position for several minutes."
<p>4. Baseline data on the problem behaviors are collected and detailed or summarized.</p> <p><i>*Note: the analysis does not need to be at a level a Board Certified Behavior Analysis would provide. It should include a summary of all the data that allows a team to determine how behavior occurred over the time period data were collected (e.g., statements such as 4</i></p>	<p>Unable to determine from FBA information if baseline data were collected in addition to school-wide sources; OR, Baseline data were collected on a behavior other than the one that is the focus of the FBA; OR, Data presented on targets that are not specific behaviors.</p>	<p>Baseline data collected on a target behavior but omits at least one of the 4 essential details (e.g., method/format, time period data collected, specific target behavior on which data were collected, analysis of data); OR, Baseline data include all of the essential components, but the time</p>	<p>Baseline data collected on the specific behavior and description addresses the 4 essential details:</p> <p>(a) target behavior on which data were collected,</p> <p>(b) method/format (e.g., frequency, rating scale, ABC, duration, etc.),</p> <p>(c) the time period of the data collection (e.g., dates, statement such as "data</p>

Component	0 = Not Addressed	1 = Partially Addressed	2 = Completely Addressed
times a day on average, 10 times a week).	<p>Example:</p> <ul style="list-style-type: none"> Data presented are on number of time-outs, restraints, or duration of time-outs rather than data on the occurrence of targeted problem behavior. Baseline data outcomes reported on "hitting" but target behavior for FBA is "cursing". 	<p>period of data collection ended more than 30 days prior to FBA date.</p> <p>Examples:</p> <ul style="list-style-type: none"> Daily; Weekly; Monthly boxes checked from a list of options for data collection, etc. but no indication of the format data was collected, time period, or analysis Baseline data summary is provided for target behavior January – April 2014 but the current FBA date is October 3, 2014. 	<p>collected over last 2 weeks), and (d) analysis of outcomes (e.g., average of 4 times a week).</p> <p>Data collected should be within 30 days of the FBA. Data may be provided in graphic, check box, or narrative format.</p> <p>Example:</p> <ul style="list-style-type: none"> Frequency data box checked, dates-9/01/10-9/05/10, hitting averages 3 times a week, and hitting was the problem behavior targeted. "Data collected over the last 3 weeks show that Jack curses 3-5 times a day." ('times' indicates frequency format).
<p>5. Setting events (i.e., slow triggers; antecedent events that provide the context or "set the stage" for a higher likelihood of problem behavior) are considered, identified (if present) and the contingency to the problem behavior is described.</p> <p><i>*Note: If the FBA identifies setting events, the hypothesis (item 8) should include the identified setting event(s).</i></p>	<p>Unable to determine based on available FBA information. No indication setting events were considered in relation to the problem behavior; OR, Events listed are not setting events (e.g., immediate triggers or antecedents, physical locations).</p> <p>Example:</p> <ul style="list-style-type: none"> Immediate antecedents such as "staff gives a non-preferred task". "Day Program" listed as the antecedent. 	<p>At least one potential setting event is identified, but fails to provide information on how the setting event predicts occurrence of the problem behavior; OR, A setting event is identified and relation between the event and behavior are described but the hypothesis (item 8) does not include the setting event.</p> <p>Example:</p> <ul style="list-style-type: none"> 'Flickering lights' is listed as a setting event but no further explanation is given. A box titled "medication" is checked but no further details on the relation of medication to the behavior occurrence is given. 	<p>At least one setting event is identified, the relation is described, AND the setting event is included in the hypothesis (item 8); OR, Data clearly indicate no setting events exist.</p> <p>Example:</p> <ul style="list-style-type: none"> Sleep deprivation is checked with further details—"When Jordan doesn't get enough sleep and he is asked to do non-preferred tasks, the problem behavior happens more frequently."
6. Antecedent events (immediate triggers) that precede and predict the occurrence of problem behavior are identified and specified.	No antecedent event most likely to trigger or predict the occurrence of problem behavior is identified; OR, Antecedent events listed would not be considered antecedents or are written	At least 1 antecedent event most likely to trigger/predict problem behavior is identified (written/through a checklist/drop-down menu), but lacks detail to	One or more antecedent events most likely to trigger or predict problem behavior are identified and includes enough detail or description to generate an intervention, AND

Component	0 = Not Addressed	1 = Partially Addressed	2 = Completely Addressed
<p>Antecedent events in which problem behavior is least likely to occur (or appropriate behavior is more likely to occur) are identified and specified.</p> <p><i>*Note: This item is determining whether the FBA identified the context in which there is an ABSENCE of the problem behavior.</i></p>	<p>in a way that is non-observable.</p> <p>Examples:</p> <ul style="list-style-type: none"> • "Individual gets upset." • "Joe slowly rocks in his seat and taps his head". • "There is no clear trigger." • "Behavior happens throughout the day" • No antecedent events most likely to trigger or predict the occurrence of appropriate behavior or absence of problem behavior are identified. • Antecedent events listed would not be considered antecedents or are not written in a way that would be observable 	<p>generate an intervention; OR, Multiple behaviors are identified in Item 2 but no clear indication of which specific antecedent events predict specific behavior(s).</p> <p>Examples:</p> <ul style="list-style-type: none"> • "Transition" is checked from a drop-down list, but no further detail given on the type of transitions that trigger behaviors. • "Staff or work demands" or "non-preferred activities" listed, but is lacking details such as the type of staff demands or the tasks involved in the demands or the specific activities that are non-preferred, etc. • Three behaviors were targeted for the FBA—"yelling out", "incompletion of work tasks, teasing peers or co-workers" and antecedents identified—difficult tasks, chaotic environments, new tasks, transitions from preferred to non-preferred, but no indication of which antecedents trigger which behaviors. • At least one antecedent event in which problem behavior is least likely to occur or appropriate behavior is more likely to occur is identified but lacks detail. • "Specials" is written or checked but no further detail is provided. • "Engaged in preferred activities (but no further description of preferred activities). 	<p>If more than one target behavior is listed, includes a clear description of which antecedent events predict each target behavior.</p> <p>Examples:</p> <ul style="list-style-type: none"> • Antecedent events for behavior 1 (fighting)—'peers make teasing comments during work time' Antecedents for behavior 2 (cussing)—'staff presents demand to do a non-preferred task such as academic related work' • One or more antecedent events in which problem behavior is least likely to occur or appropriate or pro-social behavior is most likely to occur identified and includes some detail or descriptor. • When given hands-on activities to complete task. • When allowed to work with a partner to complete a job task.
7. Consequences (i.e., how others respond immediately after problem	No events/consequences identified that occur	At least one consequence identified that occurs immediately after problem	One or more consequences identified that occur immediately after problem

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<p>behavior occurs) are identified.</p> <p>Possible maintaining contingencies (functions) are identified.</p>	<p>immediately after problem behavior; OR,</p> <p>The events listed are not immediate consequences; OR,</p> <p>Consequences listed are long-term or are inferential emotional states of person; OR,</p> <p>The consequences indicated are functions of behavior (e.g., <i>escapes</i>, <i>attention</i>) with no listing of actual responses following problem behavior that could confirm the function.</p> <p>Examples:</p> <ul style="list-style-type: none"> • Token economy (not a consequence). • "Person loses self-worth and sense of accomplishment." • "Increased stress and feeling overwhelmed" • "Staff attention" but does not describe the nature of the attention (e.g., redirects, reprimands, calming/soothing). • Automatic access/escape (no further details explaining how the person gets automatic access or automatic escape). 	<p>behavior, but lacks details; OR,</p> <p>Multiple target behaviors identified but no clear indication of which consequences follow specific target behaviors.</p> <p>Example:</p> <ul style="list-style-type: none"> • "Proximity" is identified as a consequence but no further descriptive detail. • "Removed"- (lacks details). • Two target behaviors were identified – Hitting and Off-Task. Consequences were identified as "verbal redirect", "sent to time-out", "takes points away" "peers make comments" with no indication which responses followed which of the two target behaviors. 	<p>behavior and includes some detail or descriptor, AND</p> <p>If more than one target behavior is listed, clear description of the consequences that follow each target behavior is provided.</p> <p>Example:</p> <ul style="list-style-type: none"> • Staff moves next to the person (decreases proximal distance). • Sent to the Program Coordinator (or other authority figure). • Verbal reprimand. • Redirects the person. • Peers laugh. • Peers make comments to the person. • PB1: Hitting-takes points away, sends to PC; PB2 Off Task: verbally redirects, peers make comments.
<p>8. An identifiable hypothesis or summary statement is present and includes three essential components (i.e., antecedent events, behavior, function that are linked to the antecedent events and consequences listed gathered in the FBA).</p> <p><i>Score of 0 on this item may affect scores on other items.</i></p>	<p>No identifiable hypothesis statement is included on the FBA; OR,</p> <p>A hypothesis statement is written but only has <u>one</u> component linked to FBA data; OR,</p> <p>A hypothesis statement is written but none of the 3 components is linked to the FBA data; OR,</p> <p>A hypothesis statement is written with all 3 components, the antecedent and the consequences are linked to the FBA, but the behavior in the hypothesis is not the</p>	<p>Hypothesis written in an easily identifiable statement within the FBA but only has TWO of the three components linked to the FBA data.</p> <p>Example:</p> <ul style="list-style-type: none"> • When individual is frustrated, he displays aggressive behavior to avoid doing work. (Two components present—behavior and function and are linked to FBA data; antecedent is not an antecedent). • When person is presented with a demand 	<p>Easily identifiable hypothesis written in one complete statement in the FBA, contains all three of the essential components, the behavior listed in the hypothesis is the same one identified as the focus of the FBA and all three components are linked to the FBA data.</p> <p>Examples of a Complete Hypothesis:</p> <ul style="list-style-type: none"> • When the person is given lengthy (30+ minute) work task (antecedent), s/he will throw cleaning

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	<p>behavior that was the focus of the FBA for which data were gathered and <u>no explanation of why the target behavior changed is provided.</u></p> <p>Example:</p> <ul style="list-style-type: none"> Hypothesis reads: "When Susan has difficulty staying in her area, she will leave the area to talk with another peer to avoid the non-preferred activity." <i>(The antecedent is not an actual antecedent and the FBA provided "staff demand" as an antecedent. The function is escape but the FBA did not provide any data on the response's others make following individual problem behavior that would provide support for an 'escape' function. The only component that is included is the behavior.)</i> The function of behavior is primarily to get adult attention <i>(the attention function is linked to the FBA data, but is missing the antecedent and behavior components).</i> 	<p>to do non-preferred tasks, he displays aggressive behavior because he is frustrated. <i>(Two components present and linked-antecedent and behavior; function is not valid or linked).</i></p> <ul style="list-style-type: none"> When person is presented with a demand to do non-preferred tasks, he displays aggressive behavior to avoid doing work. <i>(FBA data did not indicate demands as an antecedent).</i> 	<p>supplies all over the closet (description of problem behavior that is the same one identified as the focus of the FBA). As a result, the person is able to avoid completing the task (function of behavior).</p> <ul style="list-style-type: none"> The person shows aggressive behavior when s/he is given a non-preferred task (e.g., work tasks that are perceived difficult) which gets her/him an escape from the task.
9. Preference/Motivator/Reinforcement Assessment	No identifiable preference or reinforcement assessment is available.	<p>At least a few items are identified that have motivational power for the person; OR, Reinforcing items identified by motivational importance to person.</p> <p>Example:</p> <ul style="list-style-type: none"> Praise is recommended but not personalized to the individual. 	<p>Effective use of reinforcement is outlined, data collection methods evaluate effects, and regular review/adjustment is scheduled; AND When to/not to reinforce is identified in methods.</p> <p>Example:</p> <ul style="list-style-type: none"> Delivery of reinforcements are on data collection, along with reliable review.
10. Function of behavior is one identified in research literature, provides specificity, and is linked to	<p>No function identified; OR, No identifiable hypothesis; OR,</p>	Function is present, and is identified in research literature but is not linked to FBA data.	Function is present, is identified in research literature, and is linked to FBA data.

Component	0 = Not Addressed	1 = Partially Addressed	2 = Completely Addressed
<p>the FBA data (i.e., items above).</p> <p><i>*Note: Valid functions are positive reinforcement (access/obtain) or negative reinforcement (escape/avoid) and are observable.</i></p> <p><i>*Note: Score of 0 on this question results in a score of 0 other items.</i></p>	<p>The function is not identified in research literature.</p> <p>Example:</p> <ul style="list-style-type: none"> Function is listed as revenge, vengeance, control, power, status, frustration, autism, etc. 	<p>Example:</p> <ul style="list-style-type: none"> Function is 'attention from peer' but no FBA data indicate that problem behavior consequences result in peer attention. Function is "escape from task" but FBA consequence data indicate that peers laugh, and staff provides verbal support. 	<p><i>*Note: If the hypothesis lists multiple functions, at least one of the functions is valid and linked to FBA data.</i></p> <p>Example:</p> <ul style="list-style-type: none"> Function is 'attention from peers' and FBA data indicate that problem behavior consequences result in peer laughter, comments.

Part II: Behavior Plan (BP)			
<p>11. Behavior plan is developed in a timely manner (e.g., within 30 days) upon completion of the FBA.</p> <p><i>*Note: If the BP being reviewed is an update to a previous FBA/BP, to score a 2 the team must describe how they determined that the FBA information collected at a much earlier date is still accurate or provide a description of the FBA data they updated to confirm that the original hypothesis is still valid.</i></p>	<p>No dates included on FBA and BP to determine time span between development; OR, BP developed ≥ 60 days after FBA was completed; OR, BP date occurs prior to the FBA date; OR, BP is an update to an earlier FBA/BP and no description on how the original or preceding FBA hypothesis was confirmed for the updated BP.</p>	<p>BP developed >30 days but less than 60 days after FBA was completed based on dates provided on documents.</p>	<p>BP developed ≤ 30 days after FBA was completed based on dates provided on documents.</p> <p>Examples:</p> <ul style="list-style-type: none"> Dates clearly visible on both the FBA and BP; OR There is only one date on the document and it is clear that the FBA and BP were developed at the same time (i.e. FBA/BP occurred during one team meeting or report is a seamless narrative summary).
<p>12. Hypothesis developed from the FBA is included or referenced on the behavior plan.</p>	<p>No hypothesis is included or referenced on behavior intervention plan; OR, A hypothesis is included but is substantially different from the one included on the FBA (in all 3 components) with no explanation about the change; OR, The form is a continuous document; however, the BP targets a different problem behavior than the one included in the FBA hypothesis (item 8).</p> <p>Example:</p>	<p>Hypothesis is included or referenced on the behavior intervention plan and is similar to the one on the FBA (one or two components match), but not identical.</p> <p>Example:</p> <ul style="list-style-type: none"> The hypothesis on the FBA was "when presented with a demand to do non-preferred difficult writing tasks, the individual engages in cursing to avoid doing the demand." The hypothesis on the BIP was "when presented with academic demands, the individual engages in cursing to escape." 	<p>Hypothesis is included on the behavior intervention plan and is identical in all 3 components to the one on the FBA; OR, The BP references the FBA hypothesis; OR, The BP and FBA appear to be part of the same document (e.g., stapled together, page numbers are continuous; form numbers are sequential).</p> <p>Example:</p> <ul style="list-style-type: none"> The form is called FBA/BP, the numbers are sequential, and there was no

Component	0 = Not Addressed	1 = Partially Addressed	2 = Completely Addressed
	<ul style="list-style-type: none"> The behaviors identified in the FBA hypothesis, item 8, were "cursing, disrespect, and arguing". The behavior identified as the target problem behavior on the BIP was "physical aggression". 		observable change in any of the hypothesis components throughout the document.
<p>13. Proactive, Prevent, and/or Antecedent Strategies: A minimum of one strategy that directly addresses and modifies antecedent events listed in the "when" component of the FBA hypothesis (item 6) is identified and described in enough detail for implementation.</p> <p><i>*Note: If the hypothesis (item 8) did not include the antecedents, but the BP lists antecedent/prevention strategies that address the events listed in Items 4 or 5, score this item.</i></p>	<p>No antecedent identified in the hypothesis; OR, No direct link exists between antecedent strategies identified and hypothesis; OR, Strategies would not be considered antecedent strategies (e.g., teaching or consequential strategies rather than modifying antecedent events).</p> <p><i>*Note: If the hypothesis (item 8) did not include the antecedents, but the BP lists antecedent/prevention strategies that address the events listed in Items 4 or 5, score this item.</i></p> <p>Examples:</p> <ul style="list-style-type: none"> "transition supports" identified as antecedent strategy but FBA hypothesis does not identify transitions as an antecedent. "Provide choice of reinforcement to be earned" is identified as an antecedent strategy but as described, does not directly modify the antecedent or event that triggers the problem behavior. Instead, it provides a description of how to select a reinforcement nor does it provide enough detail about reinforcement choices to determine if any provide the function 	<p>At least one antecedent strategy is identified and directly linked to the antecedent component of the hypothesis, but does not include enough detail about the intervention procedures that would allow another person to do the intervention correctly and completely.</p> <p>Examples:</p> <ul style="list-style-type: none"> Boxes with names of antecedent strategies checked but no additional details are offered. Antecedent strategy identified and some details are provided, but essential details are missing for implementation (e.g., when to do the intervention, how to present it to the individual, etc.). Teach Joe to complete work first and then get reinforcement by saying "First do work task, then get free time". (the "when part" is vague—the description does not specify when the intervention is to be implemented in relation to the antecedent event listed on the hypothesis. 	<p>At least one antecedent strategy is identified, is clearly and directly linked to FBA hypothesis, both to the antecedent and the function, and includes enough detail describing the intervention so that it can be implemented (e.g., who is doing the intervention, when, related to the antecedent, the strategy is implemented and how—including verbal and motor behaviors of adult).</p> <p>The description is detailed enough that a stranger would be able implement the strategy with the individual and/or multiple people would implement the strategy in the same way. The description should clearly describe the strategy as preventative; that is, the intervention is implemented <i>prior</i> to individual performance of problem behavior.</p> <p>Example:</p> <ul style="list-style-type: none"> Immediately prior to presenting a demand to do a non-preferred task (<i>antecedent listed on hypothesis</i>), the staff will verbally present two choices to Jack. The choices will

Component	0 = Not Addressed	1 = Partially Addressed	2 = Completely Addressed
	that the problem behavior gets for the individual.		be which cleaning task to do first (e.g., cleaning toilets or taking out trash) and which area to do first (e.g., office area or bathroom).
<p>14. Teaching Strategies, Replacement Behavior(s), Alternative & Appropriate Behavior Strategies: A minimum of one socially valid replacement behavior that will be taught to the individual is identified, linked to the FBA hypothesis (item x), and described in enough detail for implementation.</p> <p><i>*Note: The replacement behavior can be one that is a functional equivalent (i.e., a behavior that directly asks for the function) or an alternate skill (e.g., pro-social/academically desirable) behavior.</i></p>	<p>No replacement behavior is identified; OR, Replacement behavior identified but does not serve the same function as the problem behavior or does not provide the same outcome (reinforcement) after individual engages in replacement behavior or is an alternate/desired behavior that is not incompatible with the problem behavior; OR, The identified function is not one identified in the research literature (i.e. control, revenge, status, power, etc.); OR, No function identified in hypothesis.</p> <p>Examples:</p> <ul style="list-style-type: none"> Replacement behavior identified is to "raise hand for attention", but problem behavior (calling out) occurs to escape tasks The identified replacement behavior is for the individual to "raise hand" in order to "gain control", not a research literature identified function. 	<p>At least one replacement behavior is identified and serves the same function as does the problem behavior or is incompatible with the problem behavior (e.g., alternate skill or desired behavior) but an intervention is not described with enough detail to be implemented.</p> <p><i>Note: If the function listed in the hypothesis was unable to be confirmed by the consequence information (item 7), and the intervention described links to the function and is described in sufficient detail, the item can receive a score of "1".</i></p> <p>Examples:</p> <ul style="list-style-type: none"> Replacement behavior is to "raise hand for attention", it matches the attention function but no clear description of how to implement the intervention is included, OR Replacement behavior is "remain on task" (incompatible to problem behavior), but no clear description of how to implement the intervention is provided. Teach Tracy to complete work by using a First/Then format by saying, "First finish your work, then get free time." 	<p>At least one replacement behavior is identified, serves the same function as the problem behavior or is incompatible with the problem behavior, and an intervention is described with enough detail to be implemented (i.e., a stranger would be able to implement the strategy). The detail should include the exact skill that will be taught, who will teach the skill, at what point related to the antecedent will the skill be prompted or practiced, and how the skill will be taught (instructional plan). The description is detailed enough that a stranger would be able to implement the strategy with the individual and/or multiple people would implement the strategy in the same way.</p> <p>Example:</p> <ul style="list-style-type: none"> Fred will be taught to "raise his hand" to get staff/peer attention.
15. Reactive, Consequential, or Responsive Strategies: A minimum of one strategy that eliminates the maintaining consequences (i.e., function) identified in the hypothesis and is described with sufficient detail to implement (i.e., changes the way others	<p>No strategies identified on BP to minimize reinforcement of problem behavior; OR, Strategies are identified but continue to provide same outcome (function).</p> <p>Example:</p>	<p>At least one strategy is identified on the BP to minimize reinforcement of the problem behavior and is linked to the function but is not described with enough detail to implement.</p> <p>Examples:</p> <ul style="list-style-type: none"> A box is checked from a list of possible strategies. 	<p>At least one strategy is identified on the BP to minimize reinforcement of the problem behavior, is linked to the function and is described with enough detail to implement. The description is detailed enough that a stranger would be able</p>

Component	0 = Not Addressed	1 = Partially Addressed	2 = Completely Addressed
respond to problem behavior).	<ul style="list-style-type: none"> The strategy is 'If the individual yells at the staff, the staff will remove the individual to a quiet area and the function was identified as escape. 	<ul style="list-style-type: none"> Planned ignoring is listed for a individual whose behavior resulted in attention, but no detail on how the strategy will be implemented is given. 	<p>implement the strategy with the individual and/or multiple people would implement the strategy in the same way.</p> <p>Example:</p> <ul style="list-style-type: none"> When the individual calls out, the staff will not respond (neutral facial expression, no verbal comments). If the individual continues to call-out, the staff will use a flat affect (monotone, minimal eye contact) to verbally redirect the individual to use his replacement skill.
<p>16. Safety Planning: A need for a crisis plan is considered, justified and described with sufficient detail if a need is indicated. Methods use least restrictive procedures first.</p> <p><i>*Therapeutic Response/physical restraint, if used, must be explicitly listed with plans to fade.</i></p>	<p>No crisis plan developed although product indicated a need for a plan; OR,</p> <p>No evidence or documentation provided that showed team considered the need for crisis plan.</p> <p>A crisis plan is provided, but it is a program-wide plan that is done with any individual (i.e., no individualization or customization made to crisis plan. FBA not necessary for development of the crisis plan).</p>	<p>Need for crisis plan is indicated, but procedures are not described with sufficient detail.</p> <p>Examples:</p> <ul style="list-style-type: none"> Plan does not specify who, what, when and how things will be done during a crisis situation. Plan states "office will be called to escort individual out of room" but does not provide additional details. 	<p>Need for crisis plan is indicated and procedures are described with sufficient detail; OR,</p> <p>There is documentation that the team agreed that no crisis plan is needed.</p> <p>The description is detailed enough that a stranger would be able implement the strategy with the individual and/or multiple people would implement the strategy in the same way.</p> <p>Examples:</p> <ul style="list-style-type: none"> BP indicates crisis plan is needed and specifically outlines who, what, when and how things will be done during a crisis situation. BP indicates that no crisis plan is necessary (e.g., checks a box, or provides a statement).
17. Develop & Implement Behavior Plan: A specific plan for collecting monitoring data on both the problem and replacement behaviors following	<p>No plan for collecting data on either problem or replacement behavior is included in the plan; OR,</p>	<p>A partial plan is described for either the targeted problem behavior or the replacement behavior but only includes 1, 2, or 3 relevant details (e.g.,</p>	<p>A detailed and specific plan describing who, how often, the format, and the review date for collecting outcome data on both the problem and</p>

Component	0 = Not Addressed	1 = Partially Addressed	2 = Completely Addressed
implementation of the behavior plan is included.	Unable to determine if there is a plan.	<p>who, how often, format/type, review date).</p> <p>Example:</p> <ul style="list-style-type: none"> Staff will monitor (who). Frequency box is checked (how). Staff will collect frequency data daily. (who, how, when). Plan is included, but the data are collected on a behavior that was not the focus of the FBA/BP. Graphs will be charted (no indication of who, how often, when it will be reviewed). Plan states that staff (who) will use point cards (format) but no further information provided. Boxes checked from a possible list of evaluation options, without providing any specific details. Plan describes data collection procedures for throwing objects, but the behavior addressed on the FBA/BP was hitting others. 	<p>replacement behavior following implementation of the BP is included and is linked to the target problem behavior on the intervention plan.</p> <p>Example:</p> <ul style="list-style-type: none"> Who: All staff working with the person. When: Every day at the end of each work task. Format: Rating each occurrence of the behavior. Review Date: Within two weeks.
<p>18. Monitoring: A specific plan for collecting fidelity data on BP implementation is included.</p> <p><i>*Should include when/how often, who, the method used, and a review date</i></p>	<p>No plan included on BP describing specific procedures for collecting fidelity of implementation data; OR,</p> <p>Follow-up fidelity mentioned but lacks details (who, data method, schedule of measurement, review), making plan difficult to replicate.</p> <p>Statement or description provided, but does not address a way of measuring fidelity; rather provides vague descriptions of follow-up activities.</p> <p>Example:</p> <ul style="list-style-type: none"> Statement suggesting fidelity, but lacking specific details, e.g., 	<p>Plan included on BP describing procedures for collecting data on fidelity of implementation, but is missing two or more details (who, data method, schedule of measurement, review).</p> <p>Example:</p> <ul style="list-style-type: none"> Boxes checked from drop down lists indicating who, method, schedule, and/or review dates. Statement suggesting fidelity will be evaluated but methods are lacking two or more details, e.g., "Fidelity will be evaluated once a week". 	<p>Detailed and specific plan included on BP describing procedures for collecting fidelity of implementation data (e.g., who, when, how, review).</p> <p>Examples:</p> <ul style="list-style-type: none"> The Program Coordinator will observe the plan being implemented once a week for 2 weeks and data will be reviewed in 3 weeks. The staff will complete a weekly self-assessment that will rate the degree of the plan's implementation. Data will be reviewed within 3 weeks.

Component	0 = Not Addressed	1 = Partially Addressed	2 = Completely Addressed
	<p>"Fidelity will be done".</p> <ul style="list-style-type: none"> Vague statement such as: Weekly communication between team members. 		
19. Behavioral outcomes of psychoactive medications are individually specified to aid prescriber assessing effectiveness.	Team has not accounted for any behavioral outcomes (symptom amelioration) sought from medications.	<p>Each medication and the behavioral symptom(s) to be impacted are listed in vague references.</p> <p>Example:</p> <ul style="list-style-type: none"> Explains how the medications may relate to the general symptoms of the diagnosis. Vague references or symptoms that are NOT target behaviors are included. 	<p>Each medication and symptom behavior(s) are related by empirically based relationships (e.g., antipsychotics for hallucinations vs. for aggression).</p> <ul style="list-style-type: none"> Co-pharmacy (different classes) is clearly delineated by relationship to target behaviors unique to the class (e.g., anti-depressant to social activity, antipsychotic to delusions). Polypharmacy (more than one medication of the same class) is not present.
20. Prescriber guidelines for reduction/elimination or increase/change criteria are included in plan to coordinate medical variables with plan components.	No information regarding medications or their effects in the plan.	Information about medications and general references to who is doing the prescribing, what they appear to be intended to address, and at least relevant diagnosis are included.	<p>Clear information about the symptom behaviors addressed by the medication along with clear guidance established with the prescriber about when to seek consultation about potential changes.</p> <ul style="list-style-type: none"> Increase: Clear criteria for Program Coordinator to contact the prescriber about potential increase/change in medication based upon PREVIOUS CRISES or CONDITIONS of CONCERN. Decrease: Criteria for considering a decrease discussion with the prescriber based upon SYMPTOM BEHAVIOR OBJECTIVE.

Part III: Program Implementation Review (PR)

Component	0 = Not Addressed	1 = Partially Addressed	2 = Completely Addressed
21. Monitoring: Restoration of Rights through Fading Steps of restrictions and Generalization of skills are outlined.	No recognition of or therefore plans for generalization of replacement skills nor reductions in restrictiveness of rights-limiting methods.	Intrusive or restrictive methods are identified and may have 'end dates' based on extinguishing criteria but no explicit strategy to lessen each is outlined.	Intrusive or restrictive methods are identified for Generalization and Fading. <ul style="list-style-type: none"> Generalization of successful skill developed to each environment and across situations/people are outlined Step-down strategies (fading) are detailed to lessen restrictions, gradual method elimination/reinstatement of rights
22. Monitoring: Performance data on both the problem and replacement behaviors of the behavior plan is included, shows reasonable progress, or reflects pragmatic changes.	No plan for collecting data on either problem or replacement behavior is included in the plan; OR, Unable to determine if there is a plan.	All target behaviors are clearly identified for staff to collect, with definitions. Frequency of data review, methods of graphing, staff feedback are useful.	Performance data and ancillary information, such as reinforcer delivery, are included. <ul style="list-style-type: none"> Event markers (denoting condition changes) are recorded
23. Monitoring: Fidelity data on BP implementation is included.	No evidence that data fidelity is considered.	Data and collection problems are noted, but no real plan in place to address or monitor for future management.	Methods to compensate for inter-rater reliability problems are described.
24. Monitoring: Evidence staff, family, others implementing the plan have been trained.	No evidence of staff or other support training.	All staff have been trained at least once every six months. Staff training materials include competency measures.	All staff have been trained two or more times or upon substantial changes. Example: <ul style="list-style-type: none"> Training materials have detailed methods and materials to maximize staff learning.
25. Monitoring: Motivator and delivery of reinforcement analyzed with appropriate adjustments to item, rate, and optimal use.	No data on reinforcement delivery.	Data on reinforcement delivery is present but unable to demonstrate success rates or problems.	Data is collected on the effect of motivators and delivery of the reinforcers to assure effectiveness. Example: <ul style="list-style-type: none"> Data reflects a high rate of reinforcement delivery, or exposes delivery problems

Peer Review of Behavior Supports 2.0 (PRoBeS – 2.0) SCORING FORM
Functional Behavior Assessment (FBA), Behavior Plan (BP), and Program
Implementation Review (PR)

Person Name:
 Date of Review:
 Evaluator/Team:

Component	Item	Scoring Guide	Score
Part I. FUNCTIONAL BEHAVIOR ASSESSMENT Date of FBA: <hr/> Data Gathering and Hypothesis Development	1. Interview: Input is collected from multiple people/sources to complete the functional assessment interview. <i>Check all that apply:</i> <input type="checkbox"/> Person served interview <input type="checkbox"/> Guardian interview <input type="checkbox"/> Caregiver/Staff interview <input type="checkbox"/> Indirect measures (anecdotal notes, checklists, rating scales) <input type="checkbox"/> Other:	0 = unable to determine if input was collected from multiple sources OR FBA indicates that input from one source only 1 = 1 source/person or list of names with no detail 2 = two or more sources with supporting details	
	2. Comprehensive File/Records Review: File review is conducted, summarized, and can contain things like: <input type="checkbox"/> Test scores <input type="checkbox"/> Medical history, including medications <input type="checkbox"/> Social and behavioral history <input type="checkbox"/> Strategies tried/implemented in the past and the client's response/success/lack of success with those strategies	0 = unable to determine 1 = half of the required information is present 2 = all of the required information is present and has been taken into consideration	
	3. Identify & Define Target/Problem Behavior(s): Problem behaviors are identified and operationally defined. (Easily observable and measurable, objectively defined, understood and able to be observed by anyone). If more than one behavior is identified, it is clear which behaviors will be the focus of the FBA.	0 = no problem behavior identified 1 = behaviors are identified but definitions are ambiguous or subjective 2 = ALL identified behaviors are operationally defined	
	4. Baseline data on the problem behavior has been collected and detailed and summarized. <input type="checkbox"/> Frequency, Duration, and time samples (Data collection measures) <input type="checkbox"/> Time Frame (must be done over an extended period of time) <input type="checkbox"/> Analysis of staff and environment	0 = unable to determine 1 = half of the required review information is present 2 = all of the required review information is present	
	5. Setting events (i.e., slow triggers; antecedent events that provide the context or "set the stage" for a higher likelihood of problem behavior) are considered, identified (if present) and the contingency to the problem behavior is described. <i>List setting events (slow triggers):</i> <i>Distant event(s):</i> <i>Environmental, social, or physiological events:</i>	0 = none, OR not setting events 1 = identified, no contingency 2 = identified, AND contingency described, OR clear indication no setting events exist	
Part I. FUNCTIONAL BEHAVIOR ASSESSMENT Data Gathering and Hypothesis Development	6. Antecedent events (immediate triggers) that precede and predict the occurrence of problem behavior are identified and specified. When is the problem behavior least likely to occur (or appropriate behavior is more likely to occur) are identified and specified. <i>List antecedents (triggers):</i>	0 = none, OR not antecedents 1 = identified, but lacks detail 2 = identified AND detailed	

Person Name:		Date of Review:	
Component	Item	Scoring Guide	Score
	<p>7. Consequences (i.e., how others respond immediately after problem behavior occurs) are identified. Possible maintaining contingencies (functions) are identified.</p> <p><i>List consequence(s):</i></p>	<p>0 = none, OR not consequences 1 = identified, but lacks detail 2 = identified AND detailed</p>	
	<p>8. Hypothesize/Identify the Function of the Behavior(s):</p> <p><input type="checkbox"/> Each target behavior is identified separately with the hypothesized functions explicitly listed. <input type="checkbox"/> An identifiable hypothesis or summary statement including analysis of FBA components (checklists against observations against record reviews, etc.).</p> <p>Function of behavior is one identified in research literature, provides specificity, and is linked to FBA data analysis:</p> <p><input type="checkbox"/> Function: To get/obtain (attention, tangible, sensory stimulation) <input type="checkbox"/> Function: To escape/avoid/delay (tasks, attention, tangibles, painful/uncomfortable stimuli) <input type="checkbox"/> Multiple functions</p>	<p>0 = unable to determine, no identifiable hypothesis, no function identified 1 = identifiable hypothesis and function identified but only one component or no (zero) components linked to FBA data 2 = identifiable hypothesis and function identified with 2 or more components linked to FBA data</p>	
	9. Preference/Motivator/Reinforcer Assessment	<p>0 = no assessment completed 1 = a few items are identified as motivators 2 = use of reinforcement is clearly outlined, with data collection</p>	
	FUNCTIONAL BEHAVIOR ASSESSMENT TOTAL SCORE		

<p>Date of BP:</p> <p>Part II BEHAVIOR PLAN</p>	1. Behavior plan is developed in a timely manner (e.g., within 30 days) upon completion of the FBA.	<p>0 = no dates, OR > 60 days 1 = > 30 days 2 = ≤ 30 days</p>	
	2. Hypothesis developed from the FBA is included or referenced on the behavior plan to the function of the identified target behavior(s).	<p>0 = no hypothesis, OR substantially different 1 = similar 2 = identical</p>	
	<p>3. Proactive, Prevention, and/or Antecedent Strategies: <i>anything that occurs before or prior to a target behavior ever occurring that eliminates or makes the antecedents less of a trigger to the target behavior occurring</i></p> <p><input type="checkbox"/> A minimum of one strategy that directly addresses and modifies antecedent events listed in the "when" component of the FBA hypothesis is identified and described in enough detail for implementation. <input type="checkbox"/> More than one antecedent strategy is identified and described with sufficient detail</p>	<p>0 = none identified, OR no link with hypothesis, OR no antecedent strategies 1 = one strategy identified, linked, and sufficient detail 2 = two or more strategies identified, linked, AND sufficient detail</p>	
	4. Teaching Strategies, Replacement Behavior(s), Alternative & Appropriate Behavior Strategies: <i>instructional procedures which involve the use of rearrangement or presentation of stimuli from both the physical and social environments to increase the</i>	<p>0 = none identified, OR no link with hypothesis, OR no teaching strategies</p>	

Person Name:		Date of Review:	
Component	Item	Scoring Guide	Score
Part II. BEHAVIOR PLAN	<p><i>probability of appropriate behavior. (ex. Prompting, giving instruction, demonstrating, modeling, suggesting alternatives, giving graduated guidance, providing cues, and removing provoking/tempting stimuli.)</i></p> <p><input type="checkbox"/> A minimum of one socially valid replacement behavior that will be taught to the client is identified, linked to FBA hypothesis, and described in enough detail for implementation.</p> <p><input type="checkbox"/> More than one teaching strategy is identified and described with sufficient detail</p>	<p>1 = one teaching strategy identified, linked, and sufficient detail</p> <p>2 = two or more teaching strategies identified, linked, AND sufficient detail</p>	
	<p>5. Reinforcement strategy that will reinforce the replacement behavior and provide the same outcome/function as did the problem behavior is identified and described in enough detail to implement.</p> <p><input type="checkbox"/> Positive Reinforcement – stimulus given that increases the behavior response</p> <p><input type="checkbox"/> Negative Reinforcement – offering a stimulus that the individual will work to avoid or escape</p>	<p>0 = none identified OR no link to FBA,</p> <p>1 = one type of reinforcement identified, AND linked to FBA</p> <p>2 = both types of reinforcement identified, AND linked to FBA</p>	
	<p>6. Reactive, Consequential, Responsive Strategies: <i>any strategy that is applied following the occurrence of a target behavior in response to that behavior occurring</i></p> <p><input type="checkbox"/> A minimum of one strategy that eliminates the maintaining consequences identified in the hypothesis is described with sufficient detail to implement (i.e., changes the way others respond to problem behavior).</p> <p><input type="checkbox"/> More than one reactive strategy is identified and described with sufficient detail</p>	<p>0 = none identified, OR continue to provide same outcome</p> <p>1 = one reactive strategy identified, linked, NOT sufficient detail</p> <p>2 = two or more reactive strategies identified, linked, AND sufficient detail.</p>	
	<p>7. Safety Planning: A need for a crisis plan is considered, justified, and described with sufficient detail if a need is indicated.</p> <p><input type="checkbox"/> Therapeutic Response/physical restraint, please list:</p>	<p>0 = not addressed OR need identified but no plan</p> <p>1 = procedures unclear</p> <p>2 = specific procedures identified, OR no need indicated</p>	
	<p>8. Develop and Implement Behavior Plan:</p> <p><input type="checkbox"/> Target behaviors interfere with the client's learning, a BIP is warranted</p> <p><input type="checkbox"/> BIP strategies are based on FBA data</p> <p><input type="checkbox"/> BIP is highly individualized to the client</p> <p><input type="checkbox"/> Includes positive behavior supports and strategies</p>	<p>0 = no plan, OR unable to determine</p> <p>1 = partial plan, lacks details, AND/OR does not address both problem and replacement behaviors, two or less components covered</p> <p>2 = plan fully described AND addresses both problem and replacement behaviors, all components covered</p>	
	<p>9. Effects of the behavior plan must be monitored:</p> <p>A specific plan for collecting monitoring data on both the problem and replacement behaviors following implementation of the behavior plan is included.</p>	<p>0 = no plan for data collection, OR unable to determine</p> <p>1 = partial plan, lacks details, includes two components</p>	

Person Name:		Date of Review:	
Component	Item	Scoring Guide	Score
	<input type="checkbox"/> When/How often <input type="checkbox"/> Who <input type="checkbox"/> Method <input type="checkbox"/> Review date/How often is data reviewed	2 = plan fully described, includes all four components	
	10. Behavioral outcomes of psychoactive medications are individually specified to add prescriber in identifying effectiveness.	0 = No symptom amelioration sought 1 = Each medication is listed in vague references 2 = Each medication is related by empirically based relationships.	
	11. Prescriber guidelines for reduction/elimination or increase/change criteria are included.	0 = no information 1 = information about meds and general reference to prescriber, what the med is addressing, or relevant diagnosis 2 = clear information of medication, symptoms, and prescriber input AND conditions for increase or decrease	
	BEHAVIOR PLAN TOTAL SCORE		

Part III. PROGRAM IMPLEMENTATION REVIEW	12. Monitoring: Restoration of Rights through Fading Steps and Generalization of skills restricting techniques are outlined. <input type="checkbox"/> Least restrictive interventions are used first, hierarchy is least-to-most restrictive	0 = no generalization and no fading 1 = restrictive measures are identified, but not fading plan 2 = restrictive methods are identified with clear fading plans and methods for generalization	
	13. Monitoring: Performance data shows progress towards outcomes	0 = no data included 1 = all behavior is outlined for data collection, frequency of review outlined 2 = Performance data and ancillary information is included for each target behavior	
	14. Monitoring: Fidelity Measures – <i>Is it happening? Observation of plan implementation by those responsible for implementing the plan has occurred.</i> <input type="checkbox"/> Fidelity data on Behavior Plan implementation is included <input type="checkbox"/> Staff are implementing the plan as written <input type="checkbox"/> Staff collect behavior data as indicated <input type="checkbox"/> Preventative/Proactive strategies are being followed per plan <input type="checkbox"/> Reactive/Crisis strategies are being implemented as written	0 = no evidence of fidelity consideration 1 = data collection problems are noted, but no plan to address 2 = methods to compensate for inter-rater reliability problems are described	

Person Name:		Date of Review:	
Component	Item	Scoring Guide	Score
	15. Monitoring: Documentation of staff or family training	0 = no evidence of training 1 = staff trained minimally 2 = staff/family sufficiently trained with each major revision	
	16. Monitoring: Motivational/Reinforcement Evaluation – Reinforcers continue to be effective.	0 = no data on reinforcement delivery 1 = data on reinforcement is present, but not successful 2 = data on reinforcement is collected and reinforcers are effective	
	PROGRAM IMPLEMENTATION REVIEW TOTAL SCORE		

COMPONENT	SCORE OBTAINED	SCORE POSSIBLE	PERCENT OBTAINED
I. Functional Behavior Assessment		18	
II. Behavior Plan		22	
III. Program Implementation Review		10	
TOTAL PRODUCT SCORE		50	

Peer Review of Behavior Supports 2.0 (PRoBeS-2.0)

QUICK SCORE FORM – APPROVAL SHEET

Functional Behavior Assessment (FBA), Behavior Plan (BP),
& Program Implementation Review (PR)

Directions: Score each item using the PRoBeS-2.0 Scoring Guide

Person Name: _____

Date of Review: _____

Evaluator/Team: _____

Component	Item	Score
Part I. FUNCTIONAL BEHAVIOR ASSESSMENT	1. Interview	0 1 2
	2. Comprehensive File/Records Review	0 1 2
	3. Identify & Define Target/Problem Behavior(s)	0 1 2
	4. Baseline data collected and summarized	0 1 2
	5. Setting events	0 1 2
	6. Antecedent events (immediate triggers)	0 1 2
	7. Consequences	0 1 2
	8. Hypothesize the Function of the Behavior(s)	0 1 2
	9. Preference/Motivator/Reinforcer Assessment	0 1 2
FUNCTIONAL BEHAVIOR ASSESSMENT TOTAL SCORE		
Part II. BEHAVIOR PLAN	10. Behavior Plan developed in a timely manner	0 1 2
	11. Hypothesis from FBA included	0 1 2
	12. Proactive, Prevention, and/or Antecedent Strategies	0 1 2
	13. Teaching Strategies, Replacement Behavior(s), Alternative/Approp. Behavior	0 1 2
	14. Reinforcement Strategy	0 1 2
	15. Reactive, Consequential, Responsive Strategies	0 1 2
	16. Safety Planning	0 1 2
	17. Develop and Implement Behavior Plan	0 1 2
	18. Effects of Behavior Plan Monitoring	0 1 2
	19. Outcomes of Psychoactive Medications	0 1 2
	20. Prescriber Guidelines	0 1 2
BEHAVIOR PLAN TOTAL SCORE		
Part III. PROGRAM IMPLEMENTATION REVIEW	21. Monitoring: Restoration of Rights through Fading Steps and Generalization	0 1 2
	22. Monitoring: Performance Data Shows Progress towards Outcomes	0 1 2
	23. Monitoring: Fidelity Measures	0 1 2
	24. Monitoring: Documentation of Training	0 1 2
	25. Monitoring: Motivational/Reinforcer Effectiveness	0 1 2
PROGRAM IMPLEMENTATION REVIEW TOTAL SCORE		

COMPONENT	SCORE OBTAINED	SCORE POSSIBLE	PERCENT OBTAINED
I. Functional Behavior Assessment		18	
II. Behavior Plan		22	
III. Program Implementation Review		10	
TOTAL PRODUCT SCORE		50	100

PEER REVIEW COMMITTEE DETERMINATION			
Approval from this review through: ___/___/202___		Changes Are: __ Required OR __ Recommended Only	
COMMITTEE REVIEWERS		Required changes received: ___/___/202___	

FUNCTIONAL BEHAVIOR ASSESSMENT INTERVIEW QUESTIONS

Name _____ Date of Birth _____ Sex: M F

Respondents _____

Interviewer _____

Date of Interview _____

DIAGNOSES: Please list all current known diagnoses, including psychiatric:

DESCRIBE THE BEHAVIOR/S: What behaviors are of concern?

<i>Behavior</i>	<i>Typical Frequency</i>	<i>Typical Duration</i>	<i>Typical Severity</i>
1.	1-5x/week 6-10x/week > 10x/week	1-5 min per event 6-10 min per event >10 min per event	Low Medium High
2.	1-5x/week 6-10x/week > 10x/week	1-5 min per event 6-10 min per event >10 min per event	Low Medium High
3.	1-5x/week 6-10x/week > 10x/week	1-5 min per event 6-10 min per event >10 min per event	Low Medium High
4.	1-5x/week 6-10x/week > 10x/week	1-5 min per event 6-10 min per event >10 min per event	Low Medium High
5.	1-5x/week 6-10x/week > 10x/week	1-5 min per event 6-10 min per event >10 min per event	Low Medium High

DESCRIBE THE LIKELY FUNCTION OF THESE BEHAVIOR(S): Think of each of the behaviors listed above and describe what you think the person GETS or AVOIDS by displaying the behavior:

<i>Behavior</i>	<i>What does s/he get?</i>	<i>What does s/he avoid?</i>
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

CURRENT MEDICATIONS

Medication	Dose	Times Given	Reason

(Use reverse side if more space is needed)

PREVIOUS MEDICATIONS

Medication	Dose	Dates Used	Reason Discontinued

HEALTH

What medical complications (if any) does the person experience that may affect his/her behavior (e.g., asthma, allergies, rashes, sinus problems, seizures, etc.)?

SLEEP PATTERNS

Weekdays: To bed at: _____ Wakes at: _____

Weekends: To bed at: _____ Wakes at: _____

Does the person usually:

Sleep through the night or wake often?

If they wake, does s/he get out of bed? ____Yes ____No

MEALS/DIET

Does the person have dietary **RESTRICTIONS**? What are they? Please describe the diet and mealtime routines of the person and the extent to which you think these may impact behavior.

ROUTINE

Detail the person's typical daily routine:

0500	1400
0600	1500
0700	1600
0800	1700
0900	1800
1000	1900
1100	2000
1200	2100
1300	2200

Describe the individual's behavioral response to the following situations:

	Upset behavior is:			Comments
	More likely	Less likely	Not impacted	
Given a difficult task to complete				<hr/>
A desired activity is interrupted				<hr/>
No interaction for 15 minutes or more				<hr/>
Changes in routine/schedule				<hr/>
Person cannot get something s/he wants				<hr/>
Person is left alone				<hr/>

COMMUNICATION SKILLS Please check each box that corresponds with how the person typically communicates.		Verbal				Sign			Gesture				Behavior		
Social Positive	Requesting attention or assistance														
	Requesting an object or activity														
Social Negative	Requesting escape or a break from something														
	Refusing an activity or a request to do a task														
Automatic Positive	Obtaining sensory input														
Automatic Negative	Indicating pain														

WHAT POSITIVE ALTERNATIVE BEHAVIORS ARE KNOWN BY THE PERSON?

What socially acceptable behaviors / skills does the person already do that could be ways of achieving the same function(s) as the behaviors of concern?

HISTORY OF BEHAVIOR PROGRAM EFFORTS

Provide a history of the undesirable behaviors and the programs that have been attempted.

Behavior	How long has this been a problem?	Intervention efforts	Impact
----------	-----------------------------------	----------------------	--------

ACTIVITY/ REINFORCER PREFERENCES

Please use a scale of 1-5 (1 being the most enjoyable) to indicate the person's preferences below:

Activities and sports

Puzzles	Games	Books	Sensory toys
Musical instruments	Computer games	Action figures	Painting
Bowling	Play-Doh	Trampoline	Biking
Swing set	Slide	Amusement parks	Swimming
Roller-skating	Skateboarding	Other:	

Television and video

Drama, Action, or Comedy	Animated movies	Animal videos	Cartoons
Other:		Other:	

Treats

Candy	Fruit	Pretzels	Crackers
Chips	Ice cream	Cookies	Other:

Beverages

Soda	Juice	Milk	Water
Other:		Other:	

Reading items

Pop-up books	Picture books	Books with sound	Sensory books
Puzzle books	Coloring books	Sticker books	Magazines
Other:		Other:	

Animals

Cat	Dog	Rodent	Fish
Bird	Other:		

Computer

Play Station, Xbox	Internet surfing	Social media	Other:
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Music

Country	Rock	Oldies	Classical
Rap/Hip-Hop	Other:		

Other (please list other preferences)

Credit: Dr. Brian Iwata.

SAMPLE FUNCTIONAL BEHAVIOR ASSESSMENT TEMPLATE

I. Demographics

NAME:

DOB:

DATE OF PLAN:

Address:

PC:

DDPM:

PROVIDER(s):

Behavioral Analyst (if appropriate):

REVISION DATES (LIST ALL):

II. Current Status

- A. Medical/Psychiatric Diagnoses:
- B. Identified conditions/needs through other assessments (i.e. sensory, SLP, OT/PT etc.)
- C. Target Behavior(s):
 - 1. Target behavior(s) tracked for medication effectiveness:
 - a.
 - b.
 - 2. Target behavior(s) tracked for effectiveness of behavioral techniques:
 - a.
 - b.

*(more target behaviors can be added here - this list should contain **all** present behaviors)*

- D. Operational Definition of Target Behavior(s): (include dimensions of SEVERITY/INTENSITY and DURATION/FREQUENCY)

- a.
- b.

- E. Objective(s): (summarize those relevant to the target behaviors)

- 1.
- 2.

- F. Medication being used or prescribed for Target Behavior(s)

- G. Other medications relevant to this problem: (include medications that are psychoactive and/or medications used to treat the antecedent conditions):

III. Functional assessment of Target Behavior(s)

- A. History of target behaviors and treatment effectiveness: (this includes a history of medications and treatment approaches)

NOTE: Complete this section for each target behavior.

B. Current behavioral assessment:

1a. Antecedent(s) of occurrence and absence of target behavior(s):

- a. Setting:
- b. Time:
- c. Preceding events/activities:
- d. People:
- e. other: (things that make the target behavior better or worse, increased or decreased)

1b. Consequences analysis: (what currently happens immediately following the behavior?)

- a. Reactions/Effects on others:
- b. Reaction/Effects on the individual:
- c. Without a plan, what staff usually do: There is a plan in place (see reactive strategies)
- d. Effects on the environment:

2a. Antecedent(s) of occurrence and absence of target behavior(s):

- a. Setting:
- b. Time:
- c. Preceding events/activities
- d. People:
- e. other: (things that make the target behavior better or worse or increase or decrease)

2b. Consequences analysis: (what currently happens immediately following the behavior)

- a. Reactions/Effects on others:
- b. Reaction/Effects on the individual:
- c. Without a plan, what staff usually do
- d. Effects on the environment:

NOTE: Repeat the above section for each target behavior.

- C. Interpretation of antecedent and consequence analysis: (hypotheses about the function of the target behavior, e.g., communication, task avoidance, sensory stimulation, attention seeking, receiving tangible items, etc.)

NOTE: Each number below will be a separate target behavior.

- 1.
- 2.
- 3.

- D. Reinforcing items/activities: (in no particular order - reviewed semi-monthly)

- 1.
- 2.
- 3.

V. Methods

- A. Ecological Interventions

Rationale:

Plan:

- B. Positive Programming Approaches:

Rationale:

Plan:

- C. Direct Treatment Strategies:

Rationale:

Plan:

- D. Reactive Strategies:

Rationale:

Plan:

- E. Medication:

Rationale for use (benefits):

Common Side Effects:

Serious Side Effects:

Guideline rules for medication increase/decrease:

NOTE: Each medication should be address individually in this section of the FBA.

Provisions for monthly medication review:

Who is responsible for medical treatment?

F. Evaluation and Monitoring:

1. Data Collection:
2. Summary/Reporting/Graphing:
3. Supervision of Plan:
4. In-servicing of Plan:

G. Plans for fading and generalization of interventions:

H. Procedural Safeguards:

1. All the restrictions listed in this plan will be approved by the Behavior Support Committee and Human Rights Committee **prior** to being implemented, and every six months.
2. All staff working with will be trained on this behavior plan prior to working with the individual.
3. All staff working with individuals will have completed training in Therapeutic Intervention/Therapeutic Responses/CPI prior to implementing the plan.

VI. Lesser Restrictive Alternatives Attempted or Considered prior to the implementation of the above procedure(s):

The team should identify all lesser restrictive alternatives attempted or considered. The proactive strategies and hierarchy of intervention should be used to ensure thoroughness of this process.

VII. Risk Analysis:

The team has met and agrees that the risk of using the listed medications and strategies outweigh the risks of no medication or not using behavioral interventions. (please explain how this will be beneficial).

Completed by:

Name and Title

Name and Title

POSITIVE BEHAVIOR SUPPORTS STAFF TRAINING CHECKLIST

Staff Name: _____

DATE: _____

CORE COMPETENCIES:	<input type="checkbox"/>	Explain the meanings of the words proactive and reactive and the reasons for proactive approaches.	
	<input type="checkbox"/>	Recognize external and internal factors which can increase the likelihood of them engaging in abuse/neglect/exploitation.	
	<input type="checkbox"/>	Identify factors which lead to challenging (violent/destructive) behavior.	
	<input type="checkbox"/>	Identify how the power differential can negatively impact relationships.	
	<input type="checkbox"/>	Identify the importance of understanding an individual's behavioral history, but now allowing that to negatively define how current behavior support is provided.	
	<input type="checkbox"/>	Identify the roles and responsibilities of the DSPs who support a person with challenging behavior.	
	<input type="checkbox"/>	Provide appropriate support for stages of distress/challenging behavior.	
	<input type="checkbox"/>	Identify the proactive elements of positive behavior supports and compare them to reactive responses to challenging behavior.	
	<input type="checkbox"/>	Use positive methods for calming (de-escalation) and crisis prevention.	
	<input type="checkbox"/>	Identify personal and attitudes experienced when dealing with violent or disruptive situations and positive ways to deal with these situations.	
	<input type="checkbox"/>	Respond therapeutically in crisis situations while keeping themselves and others safe.	
	<input type="checkbox"/>	Identify personal strategies to manage stress and maintain healthy relationships.	
	<input type="checkbox"/>	Identify factors which lead to power struggles, staff role in power struggles, and specific methods to prevent them from escalating.	
	<input type="checkbox"/>	Explain the hierarchy of intervention.	
	<input type="checkbox"/>	Respond therapeutically using the least restrictive intervention.	
	<input type="checkbox"/>	Demonstrate body positioning, verbal techniques for de-escalation, safe releases, blocking, and restrictive intervention techniques following the prompting hierarchy.	

Staff Signature _____ Date _____

Staff Trainer _____ Date _____

PHYSICAL INTERVENTION TECHNIQUES STAFF TRAINING CHECKLIST

Staff Name: _____

Therapeutic Responses	Date	Therapeutic Intervention	Date	CPI	Date
Stance		Stance		Supportive Stance	
Open ‘C’ Redirection					
Block		Blocks		Blocks	
Finger Release		Physical Prompt			
Wrist Release					
Hair Pull Release		Wrist & Arm Breakaway		Wrist Grab Releases	
Clothing Releases		Release from Hair Pull		Hair Pull Releases	
Bite Release		Clothing Releases		Choke Releases	
Choke Release		Bite Releases		Bite Release	
Headlock Release		Choke Releases		Transport Position	
Physical Escort		Headlock Release		Interim Control Position	
One-Arm Support & Restraint		Come-Along			
Two-Arm Restraint		Two-Person Come-Along			
Staff Switch Out		Basket Hold – Standing		Children’s Control Position	
Side Body Support & Restraint				Team Control Position	
Lifting Techniques					
Lift & Carry Techniques					
Trainer:		Trainer:		Trainer:	
Agency:		Agency:		Agency:	
Hours of training:		Hours of training:		Hours of training:	

Staff Signature _____ Date _____

Staff Trainer _____ Date _____

RESTRICTIVE TECHNIQUES QUICK REFERENCE GUIDE:

CATEGORIES OF RESTRICTIVE TECHNIQUES:

- Treated with Dignity & Respect
- Human Care & Protection from Harm
- Clean & Safe Environment
- Freedom of Movement
- Sexuality/Procreation

CONSTITUTIONAL/CIVIL RIGHTS:

- Representative/Vote in Elections
- Own, Use, & Sell Property/Possessions
- Manage & Have Access to Own Money
- Access to Legal System & Contact & Attorney
- Freedom to Practice Religion of Choice
- Privacy Over Body & Personal Affairs
- Freedom of Speech/Communication
- Freedom of Association
- Pay for Work Performed
- Due Process/Appeal

PERSONAL RIGHTS

- Participate in Planning
- Access to Own Records
- Confidentiality
- Freedom from Chemical or Physical Restraints
- Access to Information About, and Right to Refuse Treatment/Informed Consent
- File a Grievance or Complaint

Emergency Procedure Prompting Hierarchy

Use these only in emergency situations when an individual's behavior becomes severely aggressive, destructive, and/or staff are no longer able to effectively minimize the risks or are not able to safely mitigate the situation. These situations include:

- The individual is endangering themselves and/or others.
- Significant property damage is or is in real danger occurring.
- **NOT** when an individual is being noncompliant.

Non-Restrictive Measures:

- Neutral presence and open stance
- Verbal Prompting
- Calming Techniques
- De-Escalation
- Blocking (defensive blocking)
- Planned Ignoring
- Redirection with no physical contact (blocking access to areas and/or items)
- Physical Prompt

Restrictive Measures:

- Redirection with slight physical contact
- Brief Physical Hold
- Physical Hold/Restraint:
 - Side body support and restraint
 - One-arm support and restraint
 - Two-arm support and restraint
 - Two-arm restraint with second staff assist
 - Third staff assist
- Physical Transport
 - Open "C" redirection with use of one hand
 - Open "C" redirection with guided compliance or use of two hands
 - One-person physical escort
 - Two-person physical escort
 - Lifting Technique
 - Lift and Carry Technique
 - Baskethold, not on the floor (used on an individual basis and site specifically trained)

Emergency Physical Release Techniques:

- Finger release
- Wrist release
- Clothing release
- Bite release
- Hair pull release
- Chokehold release
- Headlock release

GLOSSARY: TERMS AND DEFINITIONS

This section has been developed to clarify the terms and definitions that have been used throughout this document. This information is intended to provide users with a consistent vocabulary that can be utilized to clearly communicate and understand incidents and activities.

ANTECEDENT/PROACTIVE/PREVENTION STRATEGIES is anything that occurs before or prior to a target behavior ever occurring that eliminates or makes the antecedents less of a trigger to the target behavior occurring.

AVERSIVE CONDITIONING is the application of startling, unpleasant, or painful stimuli, or stimuli that have a potentially noxious effect contingent upon the exhibition of maladaptive behavior.

AVERSIVE STIMULUS is a stimulus that is considered noxious or unpleasant. Any stimulus that individual will actively seek to avoid.

BEHAVIORAL CONTRACT is a written agreement which specifies the undesirable behavior and the contingencies placed upon it.

BEHAVIOR SUPPORT COMMITTEE (BSC) is the committee responsible to review the persons programs designed to eliminate maladaptive behavior and replace them with behaviors and skills that are adaptive and socially productive. Programs that call for any restrictive procedures must be submitted to the behavior support committee for review prior to implementation to ensure that the proposed intervention is likely to produce the desired effect, and that any risks to the person receiving services are outweighed by the risks of the behavior. The BSC should be composed of people with technical expertise, usually in a behavioral science, who can evaluate the merits of the proposed program (behavioral analyst, psychologist, or psychiatrist, all non-prescribing/non-affiliated). It would be beneficial to have a pharmacist or nurse on this committee to monitor the effectiveness of the medications the person is currently being prescribed.

CALMING AREA/SEPARATION is a calming area or separation from an environment where an individual can use to voluntarily go to calm, and where the individual has the option of coming and going freely. This may include others who are voluntarily leaving an area to allow an individual the time to calm in their present space. Staff may offer the person the opportunity to choose their own area to do this. If this is offered and is voluntary, it does not need to be taken through the Committees. If someone tells, directs, or escorts someone to a calming area, then it would need to be reported and recorded through due process.

CONSEQUENTIAL/REACTIVE/RESPONSE STRATEGIES are any strategy that is applied following the occurrence of a target behavior in response to that behavior occurring.

CORPORAL PUNISHMENT is the application of a painful stimulus to the body as a penalty for certain behavior and includes, but is not limited to: hitting, pinching, the use of electric shock, or other infliction of pain, whether or not applied as part of a systematic Behavior Plan.

DIFFERENTIAL REINFORCEMENT OF INCOMPATIBLE BEHAVIOR (DRI) is the reinforcement of behavior incompatible with the target behavior (inappropriate behavior).

DIFFERENTIAL REINFORCEMENT OF OTHER BEHAVIOR (DRO) is reinforcement given at the end of a specified period of time if the target behavior has not occurred.

EMERGENCY PROCEDURES is the use of procedures necessary to control severely aggressive or destructive behavior that places the individual or others in imminent danger of physical harm when those behaviors reasonable could not have been anticipated.

EXTINCTION is the process of discontinuing reinforcement until the behavior ceases.

FUNCTIONAL ANALYSIS (FA) can only be conducted by a qualified professional (Licensed Behavior Analyst or Licensed Psychologist) if it is within their scope of practice, after a Behavior Plan has been determined to be unsuccessful in changing or modifying a person's behavior, and a Functional Behavior Assessment (FBA) has been completed prior to the Behavior Plan being implemented. If an FBA is inadequate for

determining the function of the target behavior, and individualized behavioral strategies based on that hypothesized function found in the FBA are ineffective, then the team should consult with a qualified professional to conduct a Functional Analysis. A **FUNCTIONAL ANALYSIS** is described as explicitly and systematically manipulating antecedents and/or consequences (environmental events) to determine their effect on the target behavior, thus demonstrating a functional relationship.

FUNCTIONAL BEHAVIOR ASSESSMENT (FBA) is defined as a systemic method (process) of obtaining information related to the purpose (function) of a behavior. Indirect methods to gather the information is to include structured interviews, checklists, rating scales or questionnaires completed by someone who knows the person who engages in target behaviors and is based on their recollection of the behaviors over time. Direct methods include observations of the behaviors in relation to events that occur within the environment and include both descriptive methods (narrative), checklist method (data collected at the time the behavior takes place) or continuous data recording and scatterplots. This document must be completed prior to a Behavior Support Plan being implemented. The Functional Behavior Assessment includes ALL antecedents, behaviors and possible consequences that are part of the person's historical and current plan.

HUMAN RIGHTS COMMITTEE (HRC) is the committee responsible for assuring that the person's rights are supported and protected. Each provider agency may have its own HRC or may participate in a system wide HRC. The committee includes persons served and/or their representatives and at least one-third of the committee's members are not affiliated with the agency. All instances of alleged abuse, neglect, or exploitation where there is a violation of someone's rights are reported to the Chairperson of the Human Rights Committee in accordance with agency policy, state law, and provisions of this policy. Members of this committee will have training or experience with issues and decisions regarding human rights and behavioral supports. These may include, and are not limited to, judges, consumer advocates, attorneys, members of the clergy, ethicist or other persons with prior experiences with human rights and behavioral support committees.

INCOMPETENCE is the lack of ability, legal qualification, or fitness to discharge the required duty (each agency needs to define the qualifications and especially the required duty).

INFORMED CONSENT is a process which includes informing the individual and/or the individual's legal guardian of the behavioral intervention, the potential risks and benefits of the intervention, as well as obtaining a signed agreement to implement the behavioral intervention.

INTERDISCIPLINARY TEAM consist of the persons participating in the planning process with the individual, which may include the individual's family and/or guardian, advocate, professionals qualified in the relevant disciplines, and other persons who are personally familiar with the individual.

LIMITED ACCESS is limiting a person's access to any personal possessions, area, people, or rights.

MECHANICAL RESTRAINT occurs when a physical device or devices are used to restrict the movement of a person or normal function of a portion of his/her body (i.e., belts, straps). ***Note: mechanical restraint does not include the following when ordered by a physician and/or addressed with the person's plan: orthopedically prescribed appliances; surgical dressings and bandages; devices used to provide support for the achievement of functional body positions, proper balance, or to protect a person from falling.*

MEDICATION occurs when a person is prescribed/given medication for the purpose of immediate control of the individual's behavior. This would include regularly scheduled medication and PRN medication. ***Note: Medications used to stop or inhibit the growth and physical development, and/or activities such as sexual activity are a restrictive form of treatment and an invasion of individual rights, but for these purposes, are not considered a 'restraint', but do not need to be taken through the BSC and HRC.*

MONITORING DEVICE is any device used to identify the location or activities of an individual (e.g., chime or alarm on a door, monitor in a room, bed alarm, chair alarm, surveillance camera, window alarm, etc.).

ND HRC/BSC PROVIDER TOOLKIT is the tool kit that was put together from various stakeholders for the

benefit of the agency, and their respective committees, to use for training and guidance as HRC/BSC processes are reviewed and updated. There are other tools, forms and guidance in this toolkit.

NEGATIVE REINFORCEMENT is the offering of a stimulus that an individual will work to avoid or escape.

NEGLECT is the omission of proper care, treatment, and supervision by staff. Refer to ND Century Code or Child Abuse or Neglect definitions.

NON-AVERSIVE BEHAVIOR INTERVENTION is any contingency managed procedure written for the purpose of redirection or reduction of a behavior where the procedure is based on a Functional Analysis and delineates positive reinforcement scheduled and other positive stimulus variables.

NON-EXCLUSIONARY TIME OUT is a Level 1 technique in which positive reinforcement is withdrawn for a pre-specified period of time following the performance of misbehavior. The individual can remain in the reinforcing environment but is not allowed to engage in reinforcing activities for a specified period of time.

ONE-MONTH EXTENSION can be granted to run the “old plan” or “current plan” until the new plan is reviewed and approved.

OVERCORRECTION is a specific type of punishment technique designed to minimize negative reactions caused by scolding or other punitive intervention. It has two basic components: 1) To overcorrect the environmental effects of an inappropriate behavior, and 2) To require the disrupter to practice overly correct forms of relevant behaviors.

PHYSICAL ABUSE those situations involving physical aggression (e.g., hitting, kicking, slapping) towards an individual by any staff.

PHYSICAL RESTRAINT are manual methods or mechanical devices that are intended to restrict the movement or normal functioning of a position of the individual's body (e.g., splints, Posey mittens, and straitjackets). Excluded are physical guidance and prompting techniques of brief (less than two minutes) duration and mechanical supports to position or support an individual.

POSITIVE REINFORCEMENT is the offering of a stimulus that, when presented as a consequence of a response, results in an increase or maintenance of that response.

PREMACK PRINCIPLE is a technique that states the contingent access to high frequency behavior to serve as the reinforcer for the performance of low frequency behavior. This is often stated as, “First _____, Then _____.”

PHYSICAL INTERVENTION occurs when a manual method is used to restrict a person's movement or normal access to his/her body.

PSYCHOACTIVE/PSYCHOTROPIC MEDICATIONS are any medication prescribed by a physician for the primary purpose of addressing symptoms of psychiatric disorders (e.g., antidepressants, stimulants, major/minor tranquilizers, beta-blockers, and anti-seizure medications).

QUORUM is the total membership divided by half plus one (i.e., 51% must be present; or there are 8 members total and half of that is $4 + 1 = 5$ needed for quorum) and 1/3 of the voting members should not be affiliated with the agency reviewing and approving the plans.

REIMBURSEMENT/RESTITUTION is giving back or replacing the cost of something that has been taken, lost, or damaged.

RESPONSE COST is the removal of possessions/privileges, or other previously earned rewards in response to identified target behavior(s) (e.g., if an individual threatens staff, co-worker, or housemate, they will lose their pop for the day).

RESTRAINT means bodily physical restriction, mechanical devices, or any device that limits freedom of movement and includes mechanical restraint, physical restraint, and chemical restraint (which is medication that might be used to control behavior, such as in an emergency situation or per their medication or behavior intervention protocol, such as a PRN – *Pro re nata* “as needed” or “as the situation arises” order).

RESTRICTION is the limiting of access to an area/areas, objects, or rights, that are generally accessible to

other people.

SATIATION is the reduction in performance of reinforcer effectiveness that occurs after a large amount of that same type of reinforcer has been delivered (usually within a short time period) following the emission of the behavior.

SEARCH AND SEIZURE is a procedure implemented to remove an item from an individual that has been determined to be unsafe or poses a risk of harm to the client.

SECLUSION is defined as the involuntary confinement of an individual alone in a room or an area from which the individual is physical prevented from having contact with others or leaving. This may also involve moving a person's personal items away from them in order to prevent them from leaving the area. *Note: DD Policy prohibits the use of SECLUSION and prone restraints in Licensed DD Facilities.*

STIMULUS CHANGE is any non-noxious event which temporarily interrupts a behavior (e.g., tossing candy on a table to interrupt stereotypic behavior).

TEACHING TECHNIQUES/STRATEGIES are instructional procedures which involve the use of rearrangement or presentation of stimuli from both the physical and social environments to increase the probability of appropriate behavior (e.g., prompting, giving instruction, demonstrating, modeling, suggesting alternatives, giving graduated guidance, providing cues, and removing provoking/tempting stimuli).

THERAPEUTIC INTERVENTION are techniques, either verbal or physical, used to diffuse a potential explosive situation when an individual may be of harm to self or others. Physical techniques include basket holds, come along, blocks, releases, and break away.

TIMEOUT is a procedure in which positive reinforcement is withdrawn for a pre-specified period of time following the performance of a behavior, either with the individual remaining in the reinforcing environment (non-exclusionary) but is not allowed to engage in the reinforcing activity, or the individual is removed (exclusionary) from the reinforcing environment, either to a timeout room, placed behind a partition, or required to move to a place away from others. Non-exclusionary Timeout may ONLY be used as a part of an APPROVED plan (i.e., not to be used on an emergency basis). *Note: Exclusionary timeout is NOT an approved intervention method under DD Licensure. Exclusionary timeout is allowed at an ICF/ID at the Life Skills & Transition Center. The Life Skills & Transition Center may not be licensed or accredited in the same manner or by the same entities as other DD Providers. As a result, there are some variation in their policies and procedures.*

TOKEN REINFORCEMENT is the offering of an object that can be exchanged at a later time for another reinforcing item or activity.

VERBAL ABUSE is any language that is damaging to an individual's self-esteem or that may reduce the individual's dignity when observed or overheard by others (e.g., shouting, screaming, swearing, name calling, etc.).