

George E. Pataki
Governor



Thomas A. Maul
Commissioner

STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

44 HOLLAND AVENUE
ALBANY, NEW YORK 12229-0001
(518) 473-1997 • TDD (518) 474-3694

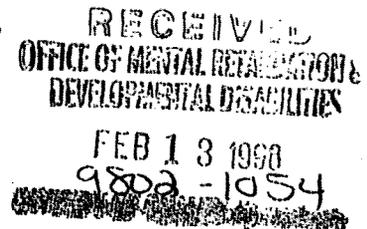
MEMORANDUM

TO: Executive Directors of Voluntary Agencies
DDSO Directors

FROM: Thomas A. Maul
Commissioner

DATE: February 10, 1998

SUBJECT: Guidelines for SCIP-R



I am pleased to announce that the training curriculum "Strategies for Crisis Intervention and Prevention - Revised" (SCIP-R) is currently available through the Office of Work Force Development at the address above. This revised curriculum replaces "Strategies for Crisis Intervention and Prevention" (SCIP, 1988) and will serve as OMRDD's program for training staff in a sequential process for crisis prevention and intervention. Training updates for SCIP-R will be provided by each DDSO.

The SCIP-R curriculum has been expanded and incorporates a number of improvements, including a greater emphasis on using positive strategies when addressing challenging behaviors and additional material on crisis prevention. There have been changes in several personal intervention techniques with the continued focus on ensuring the health and safety of all persons involved should a behavioral crisis occur. I am sure that you will find SCIP-R to be a valuable asset to your training program.

In order to ensure quality training and consistent implementation of the SCIP-R curriculum, revised Guidelines have been developed. These Guidelines are enclosed with the expectation that they will be implemented whenever the SCIP-R curriculum is utilized. To afford a smooth transition, there will be a six month phase-in period with SCIP-R becoming OMRDD's approved training program effective August 10, 1998.

Your cooperation in the implementation of these guidelines is appreciated.

TAM/PFP
Enclosure

cc: Leadership Team





STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES
GUIDELINES
FOR
STRATEGIES FOR CRISIS INTERVENTION and PREVENTION - REVISED
Training and Implementation

Strategies for Crisis Intervention and Prevention - Revised (*SCIP-R*) is now the Office of Mental Retardation and Developmental Disabilities' (OMRDD) approved program for training staff in a sequential process in the development of skills for crisis prevention and intervention, and replaces *SCIP*. The focus of this revised program is to empower staff with methods of assisting and teaching individuals to maintain self-control and to train staff to engage in proactive methods of positive behavior support. The *SCIP-R* curriculum supports staff awareness of the needs of persons with developmental disabilities and methods of preventing crises.

OMRDD maintains a strong commitment to crisis prevention and positive behavior supports; however, it is sometimes necessary to respond to a behavior crisis and to use personal interventions. The *SCIP-R* program has been designed to ensure competence when responding to a behavior crisis and using personal interventions. In order to facilitate safe and effective implementation of the entire *SCIP-R* program, the following guidelines shall be adhered to by any and all facilities utilizing the *SCIP-R* curriculum, both when training staff and when staff utilize *SCIP-R* personal intervention techniques. Only those personal intervention techniques taught within the *SCIP-R* curriculum are approved for use. Recognizing the right of people to exercise the fullest range of experiences, choices and opportunities possible, it is OMRDD's intent to minimize the use of personal interventions and to emphasize sound behavior support programs based upon individual needs.

I. Training recipients of the *SCIP-R* Program

Staff with direct service responsibilities and their supervisors should be trained in *SCIP-R* based upon needs of individuals receiving services. A modified program may be offered to staff who do not have direct service responsibilities. However, staff receiving a modified program cannot be considered certified in *SCIP-R*. Lack of *SCIP-R* training does not preclude staff from responding to an emergency situation to safeguard the welfare of a program participant and/or employee. All staff members and volunteers are to be familiar with OMRDD regulation, Part 633 - Protection of Individuals Receiving Services.

II. Requisite Training

Training in *SCIP-R* is only one component of a total staff training program. Restrictive Personal Interventions can only be used by staff who have received instruction on the following topics: basic first aid and cardiopulmonary resuscitation.

It is recommended that staff shall also receive training in *Positive Approaches to Behavior Change* or a similar training program that emphasizes positive behavior support strategies.

III. Certification

Certification in *SCIP-R* at the Core Level will be awarded upon successful completion of each of the six units of the *SCIP-R* program including demonstration of competency performance in the core personal intervention techniques. Successful completion of a written test with at least 80% correct responses based upon *SCIP-R* principles is also required. Annual recertification shall include a refresher course with similar competency evaluations.

For all staff who complete the training program, there is to be an indication in their training record of course completion or certification. Any exclusions or partial certification (e.g., inability to do personal intervention techniques because of a medical condition) is also to be indicated in the training record. A certificate of completion should indicate whether a person has learned Core and list any additional Specialized or Restrictive Personal Intervention Techniques.

IV. Instructors, Instructor-Trainers, Master-Trainers

Those people who provide training shall be certified in one of the following categories:

A) Instructor, B) Instructor-Trainer or C) Master-Trainer.

Instructors are responsible for providing training directly to staff. Instructor-Trainers train and monitor Instructors. Master-Trainers prepare and monitor Instructor-Trainers and monitor *SCIP-R* within their DDSO for both State and Voluntary operated programs. All Instructors and Instructor-Trainers previously certified in *SCIP* will be considered certified in *SCIP-R* upon a comprehensive review of the *SCIP-R* training curriculum and guidelines, and must meet the certification requirements listed below. DDSOs may increase the criteria for selection, certification and responsibilities.

A. Instructor

1. Selection

Instructors for *SCIP-R* must:

- a. Demonstrate sensitivity to persons with challenging behaviors.
- b. Receive training in positive behavior support strategies.
- c. Receive administrative approval to be an Instructor.
- d. Have sufficient time allocated to participate.
- e. Have current certification in *SCIP-R*.
- f. Be employed by a provider agency operated or certified by OMRDD.

2. Certification

Instructors in *SCIP-R* are certified by Instructor-Trainers upon:

- a. Attending an Instructor training program.
- b. Assisting in teaching the complete program with another Instructor at least once

- c. Teaching the complete program under the observation and supervision of an Instructor-Trainer.
- d. Completion of a training program in Positive Approaches or a similar program.
- e. Attending refresher sessions for Instructors conducted by Instructor-Trainers.
- f. Being reviewed periodically by Instructor-Trainers.

3. Responsibilities

- a. Teach at least one program annually.
- b. Document and report training conducted.
- c. Maintain the integrity of *SCIP-R*.

B. Instructor-Trainer

1. Selection

- a. Must be a certified Instructor.
- b. Sufficient time allocated to participate.
- c. Received administrative approval to be an Instructor-Trainer.
- d. Experience working with people with challenging behaviors.

2. Certification

Instructor-Trainers in *SCIP-R* are certified by Work Force Development upon:

- a. Teaching an Instructor training program under the supervision of a certified Master-Trainer.
- b. Recommendation by the certified Master-Trainer to Work Force Development.
- c. Attending updates related to training.
- d. Completion of a train-the-trainer workshop in *Positive Approaches To Behavior*.
- e. Maintaining Instructor certification.

3. Responsibilities

- a. Certify *SCIP-R* Instructors.
- b. Maintain records of Instructors certified.
- c. Evaluate the performance of Instructors.
- d. Monitor implementation of *SCIP-R* training within their organization including a periodic review of Instructors.
- e. Support the development of *SCIP-R* Instructors.

C. Master-Trainer

1. Selection

- a. Master-Trainers will be recommended by each DDSO.
- b. Must be a DDSO employee.

2. Certification

- a. Must have Instructor-Trainer certification.
- b. Certified by OMRDD Work Force Development.

3. Responsibilities:

- a. Responsible for monitoring *SCIP-R* throughout the DDSO.
- b. Function as liaison between Work Force Development and Instructor-Trainers and Instructors in the DDSO.
- c. Attend Master-Trainer updates.
- d. Keep Work Force Development informed of all instructor trainer certifications.

V. *SCIP-R* Coordination

Statewide *SCIP-R* implementation will be coordinated by Work Force Development with updates communicated directly to DDSO Master-Trainers.

If Personal Intervention techniques other than those taught within the *SCIP-R* program are required, they must be forwarded to Work Force Development for review and approval prior to use. Such new techniques are to be designed in accordance with principles of good body alignment, concern for circulation and respiration, to avoid pressure on joints, and not likely to inflict pain or cause injury.

If a Personal Intervention technique needs to be adapted due to a particular person's physical disability, that technique shall be reviewed and sanctioned by a committee (e.g., Behavior Review Committee), and shall be designed and implemented for that person only.

VI. Prevention

In all cases, the best method for avoiding severe behavioral crises is prevention through positive behavior support. This may be achieved using information gained from a functional analysis to modify environments and devise plans to teach and assist individuals to use alternative means to achieve personal outcomes. Inherent in this approach is the need for staff to learn to teach new skills and to promote maximum participation for everyone in meaningful daily experiences including learning to maintain self-control. When Personal Intervention techniques are required during a behavioral crisis, such techniques are temporary control measures and are not a substitute for habilitative services.

VII. Role of the Planning Team

A person's plan of services is designed by a team based upon the person's preferences and desires, with the aim of improving his/her quality of life. At times, challenging behaviors may interfere with the person's success and should be addressed through planned proactive interventions. If crisis intervention techniques are required, the Team is to review and, when necessary, revise the person's plan of services with a focus on the elimination of the need for the use of Personal Intervention techniques and implementation of increased positive behavior supports.

Psychologists or applied behavior sciences specialists are key members of a Planning Team involved in the development, training, implementation, and evaluation of behavioral strategies including crisis intervention. Psychologists are encouraged to participate in training staff in *SCIP-R* and *Positive Approaches to Behavior Change*. Psychologists should be involved in monitoring the use of personal intervention techniques and designing positive strategies for behavior support. Psychologists are encouraged to become certified in *SCIP-R*.

As members of the Planning Team, health care professionals are to be familiar with Personal Intervention techniques and participate in decisions regarding their use. Medical conditions of individuals receiving services that may contraindicate or limit use of Personal Intervention techniques must be evaluated and documented on a person specific basis, once utilized in an emergency and/or prior to their planned use.

VIII. Use of Personal Intervention Techniques

Personal Intervention Techniques are grouped into three categories: Core, Specialized, and Restrictive. Core Interventions are the techniques taught to everyone who takes *SCIP-R* for certification. Specialized and Restrictive Interventions are available to be taught on an as needed basis. Restrictive Interventions are the most intrusive, to be taught only when absolutely necessary, and are not to be considered part of the core training. Therefore, only staff working with individuals who require Restrictive Personal Interventions should be trained to use restrictive interventions. [Note: The Lying Wrap-Up is no longer included in the *SCIP-R* curriculum.]

A. The SCIP Gradient

If preventive steps are unsuccessful or not feasible in averting a behavioral crisis, and if the person is in danger of hurting himself or others, approved personal intervention techniques may be used on an emergency basis. These techniques are to be used only until the person is calm. Such techniques are only used after other methods of intervention (early intervention, non-verbal, and verbal calming techniques) have been considered, and determined to be clinically inappropriate and unlikely to succeed, or have been tried and have failed.

- Personal Intervention Techniques are defensive interventions and are not to be used offensively. Excessive force in the use of any personal intervention technique may constitute abuse.
- Personal Interventions follow a gradient system of implementation. The minimal amount of intervention to help a person gain control should be utilized. A sequence of least restrictive to more restrictive techniques should be followed.
- Restrictive Personal Interventions - are considered to be the most intrusive. These techniques are only to be employed to interrupt or terminate a truly dangerous situation where serious injury could result.

- Whenever Restrictive Personal Intervention techniques are utilized on an emergency basis more than two times during a thirty day period, the person's Team must address the behavior(s) by conducting or reviewing a functional analysis and revising a person's plan of services as necessary to address the challenging behaviors using positive behavior supports.

B. Monitoring and Documentation

The use of Restrictive Personal Interventions Techniques are to be documented in the person's clinical record, and include:

- A description of the behavior and situational/environmental conditions which necessitated the use of the intervention; the name(s) of the person(s) implementing the intervention; the personal intervention technique used; the time of initiation and termination; outcome and resolution.

The use of all Restrictive Personal Intervention Techniques is to be monitored on an agency-wide basis with the frequency of use, as well as staff and consumer injury summarized on a monthly basis. Such monitoring is to include the use of these techniques both on an emergency and planned basis. This is to be done to evaluate the impact of these techniques on individuals and groups with the overall goal of reducing the frequency of their use. Consistent with Part 624, any unauthorized or unnecessary use of a Personal Intervention may constitute physical abuse and will be investigated accordingly.

IX. Health and Safety Considerations

When utilizing personal interventions techniques, the person's health and safety must always be considered and monitored. A minimum amount of force is to be utilized, with the hold gradually released as the person begins to calm. Always assess the possibility of moving to a less intrusive intervention, with the goal of releasing the person as soon as possible. The individual's circulation, respiration and state of consciousness must be monitored. An open airway passage must be ensured. The use of any personal intervention must be terminated immediately if the individual shows signs of physical distress, such as sudden change in color, hyperventilation, difficult breathing, or vomiting. Excessive struggling may indicate severe physical distress.

Staff are to be especially cautious about initiating a Restrictive Personal Intervention if a person has recently eaten a meal because of the risk of death due to aspiration. If a Restrictive Personal Intervention should be determined to be necessary due to the critical nature of the situation, and the person has eaten recently, it is even more important to monitor for the signs of physical distress mentioned above and to attempt to have the person respond vocally to staff efforts at verbal calming.

The use of a Restrictive Personal Intervention presents a risk whenever it is employed, and should not be used when there is a medical contraindication. Such medical conditions may include cardiac or pulmonary problems, physical disabilities and other medical problems identified by a health care professional. This is particularly true for persons with Down

Syndrome due to their particular physiognomy. Persons with this congenital disability typically have broad, flat faces and noses, and short necks with smaller oral cavities, yet larger tongues. This condition may result in a compromised air exchange, interfere with oxygen intake, and enhance the possibility of asphyxia. Respiratory difficulties can be further accentuated if the person is agitated and struggling. Another known abnormal feature of Down Syndrome is the increased potential for the dislocation of the first cervical vertebra, which is near the respiratory control center. Excessive pressure applied to the region of the neck could result in the dislocation of this vertebra and inhibit breathing.

If an individual continues to be held in a Restrictive Personal Intervention for 10 minutes, a supervisor is to be notified. The application of a Restrictive Personal Intervention technique shall be done with the minimum amount of force necessary to safely interrupt the behavior, and the duration of the application of a single episode should not exceed 20 minutes.

Subsequent to the use of any Restrictive Personal Intervention, a staff member (preferably a health care professional) is to examine the person for evidence of injury and so document.

LISTING OF PERSONAL INTERVENTION TECHNIQUES:

CORE

To be taught to all certified staff

Touch
One Person Escort
One Person Escort-Seated Variation
Two Person Escort
Two Person Escort-Seated Variation
Arm Control By One Person or With Assistance
Standing Wrap
Front Deflection

Bite Release
One Arm Release
Two Arm Release
Front Choke Windmill Release
Back Choke Release
Front Hair Pull Stabilization/ Release
Back Hair Pull Stabilization/Release
Back Hair Pull Stabilization/Release With Assistance

SPECIALIZED

To be taught based on program needs

Blocking Punches
Seated Wrap
Head Support
Approach Prevention
Front Arm Catch
Bite Prevention Front Hold
Front Choke Release
Head Lock Prevention
Head Lock Release
Slip Punch to Wrap

Front Kick Avoidance/Deflection
Back Choke Arm Catch to Wrap
Back Hold Under Arms Release
Back Hold Low Over Arms
Back Hold High Over Arms to Wrap
Chair Deflection
Protection from a Chair as a Weapon
Protection from Thrown Objects
One Person Wrap/Removal
Two Person Removal

RESTRICTIVE

To be taught on an as needed basis only

Two Person Take Down
Two or Three Person Supine Control
One Person Take Down

One Person Take Down to Side Control
One Person Take Down to Seated Control
Seated Control to Supine Control