

Appendix F: Qualitative Guidance on Intensive Behavioral Services

Purpose

The purpose of this Appendix is to provide guidance for Intensive Behavioral (IB) Services' providers (agencies and staff) on 1) best practices for behavioral interventions, 2) elements that should be included in the Functional Behavioral Assessment (FBA) and Behavior Management Plan (BMP), and 3) other required practices within IB Services.

Guidance on Behavioral Interventions

All interventions designed to manage challenging or maladaptive behaviors should be in conformance with applicable laws and regulations and agency specific policies/procedures. Such behavioral interventions shall actively include positive strategies designed to establish or increase the person's adaptive (replacement) behaviors.

Such behavioral interventions shall be designed and implemented for the explicit purposes of developing or increasing adaptive behaviors (a.k.a. replacement behaviors) as well as decreasing the frequency of challenging or maladaptive behaviors, but never used for the convenience of staff, as a threat, as a means of retaliation or retribution, for disciplinary purposes, or as a substitute for supervision.

Positive behavioral approaches, strategies, and supports that are consistent with standards of professional practice shall always be the preferred method for addressing challenging or maladaptive behavior, with the overall goal of increasing the person's repertoire of adaptive behaviors and skills. These positive approaches should include a variety of proactive strategies such as providing access to preferred activities and items, and providing choice-making opportunities; setting event strategies; active teaching of replacement or alternative behaviors such as functional communication, anger management, behavioral self-management, relaxation and social skills; positive reinforcement, shaping, differential reinforcement procedures; environmental modifications and safeguards; and/or "Time away" (when a person is verbally redirected to go to a quieter or less stimulating area of the residence/program and where staff or care providers do not actively prevent egress from that area); etc.

Strategies and supports to address challenging or maladaptive behaviors that pose a more *immediate* risk of harm to self or others will be addressed through the least restrictive or least intrusive method possible. These methods should be identified in the individual-specific Behavior Management Plan and may include: physical response-blocking or response interruption (e.g., momentarily preventing an individual from engaging in certain movements that could lead to injury such as hand-to-head self-injurious behavior (SIB) by physically blocking the individuals' hand from touching his/her head by inserting a hand/arm or soft object to block the SIB attempts, briefly [10-15 seconds] and gently physically guiding and holding an individual's hands down to their lap or sides to prevent SIB or aggression attempts, etc.); "extraordinary blocking" strategies (the use of protective gear such as arm guards, shin guards, chest protectors, padded mitts and/or small padded bolsters by staff or parents/caregivers to prevent injury to the person and care providers during the course of aggressive behavior, SIB, and/or severe agitation); or protective and defensive strategies (this includes front deflection, bite

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release, one or two arm grab releases, front or back choke releases, front or back hair pull releases, and blocking punches as currently defined in the OMRDD training curriculum).

Intervention strategies that are considered more restrictive or intrusive should only be implemented after more proactive or less intrusive measures have been attempted and proven ineffective or unsuccessful. More restrictive methods should only be used as part of an intervention plan that includes abundant specific and individualized positive reinforcement for adaptive behaviors. Examples of more restrictive or intrusive strategies include: *non-exclusionary* time-out (specifically removing and/or preventing access to reinforcers for a brief period of time following occurrences of challenging or maladaptive behavior, but not removing the individual from the room or location they are in, e.g., “Chair Time-out” for five minutes during which time the person is under constant visual and auditory contact and supervision by the staff or care provider.); physical response-blocking or response interruption; or response cost (e.g., token fines as part of a token economy system).

Some individuals receiving IB Services may require specific health and safety interventions prescribed by a physician for their treatment or protection due to SIB, aggression, agitation, hyperactivity, depression, anxiety, etc., including-- but not limited-- to medication(s) or mechanical devices (helmets, arm sleeves/splints, Posey mitts, etc.). These forms of health and safety interventions or treatments can only be used as directed in a physician’s order and therefore should not be incorporated into the Behavior Management Plan developed through IB Services. Rather, these health and safety interventions or treatments should be referenced in their Individualized Service Plan and/or habilitation plan.

There shall be sufficient safeguards and supervision to ensure that the dignity, safety, health, welfare, and civil rights of a person have been adequately protected. No Behavior Management Plan shall:

1. incorporate sleep deprivation as a direct consequence of challenging or maladaptive behavior;
2. deprive a person of a balanced and nutritious diet;
3. incorporate the use of food such that the form of the food served is altered to make it distasteful or less appealing as a reactive consequence for challenging or maladaptive behavior;
4. incorporate the use of *aversive* intervention in any form. For purposes of this section, “aversive intervention” means an intervention that is intended to induce or inflict pain or discomfort to a person for the purpose of modifying or changing a person’s behavior or eliminating or reducing challenging or maladaptive behaviors, including but not limited to the following:
 - a. contingent application of noxious, painful, intrusive stimuli or activities;
 - b. any form of noxious, painful, or intrusive spray (including water or other mists), inhalant, or tastes;

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- c. use of helmets, mechanical restraint devices, or other means of movement limitation *as a punishment* (NOTE: This does not include use of helmets or other mechanical devices for health and safety purposes as ordered by a physician); and
- d. the use of blindfolds, white noise helmets, and electric shock.

Guidance on the Creation of the FBA and the BMP

The Functional Behavioral Assessment (FBA) and Behavior Management Plan (BMP) must be developed by a Licensed Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), or an individual with a Master's degree in a clinical and/or treatment field of psychology from an accredited institution [Reference 14 NYCRR 679.99 (q) & (t)]. Certain agency staff with a Master's degree in a related human services field from an accredited institution, and specialized training or experience in conducting functional behavioral assessments and developing behavior management plans, may be approved by the DDSO to deliver IB Services. See Appendix C for more specific details regarding the qualifications and supervision requirements for staff who are authorized to deliver IB services.

The clinician shall develop the FBA and BMP in consultation with the person (when feasible), the person's parent(s) and/or caregiver(s) and other clinical experts as needed.

Elements of the FBA

Prior to the development of a BMP to address challenging or maladaptive behavior, a functional assessment of the behavior must be completed to obtain relevant information for intervention planning. An FBA should:

1. identify/describe the problem behavior(s) in concrete terms;
2. identify and explain the likely reason or purpose for each challenging or maladaptive behavior;
3. identify the general conditions or probable consequences that may be maintaining each behavior;
4. include consideration of the antecedents of the identified challenging or maladaptive behavior(s);
5. identify the contextual factors, including cognitive, physical, medical and/or psychiatric conditions, that create or may contribute to each behavior;
6. include an evaluation of whether and how contextual and/or environmental alteration(s) or interventions would reduce or eliminate each behavior or behavioral sequence;
7. include an assessment of preferred reinforcers;
8. consider multiple sources of data including, but not limited to:
 - a. information gathered through direct observations of the individual;

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- b. information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and
 - c. a review of available clinical, medical, behavioral, or other data from the individual's record and other sources.
9. not be based solely on an individual's documented "history" of challenging or maladaptive behaviors; and
 10. provide a baseline of the challenging or maladaptive behaviors including frequency, duration, intensity and/or latency across settings, activities, people, and times of day or seasons.

Elements of the BMP

All BMPs should:

1. be developed on the basis of a functional behavioral assessment of the behavior;
2. include a concrete, specific description of the challenging or maladaptive behavior(s) targeted for intervention;
3. include positive behavioral approaches, strategies and supports to address the behavior(s) requiring intervention;
4. include a plan for actively reinforcing and teaching the person alternative skills and adaptive (replacement) behaviors;
5. provide a method for collection of positive and negative behavioral data with which treatment progress may be evaluated;
6. include a schedule (e.g., daily, weekly, monthly, etc.) to review the effectiveness of the interventions included in the BMP, including examination of the frequency, duration, and intensity of the challenging or maladaptive behavior(s) as well as the replacement behaviors;
7. include measurable short and long-term objectives regarding increase of adaptive behaviors being taught and reinforced; and reduction of the challenging or maladaptive behavior(s) targeted for intervention; and

A BMP which incorporates a restrictive or intrusive intervention must include the following additional components:

1. a concrete description of the person's behavior that justifies the incorporation of the restrictive intervention(s) to maintain or assure health and safety and/or to minimize challenging or maladaptive behavior;

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2. a description of all positive, less intrusive, or other restrictive/intrusive approaches that have been tried without success prior to the inclusion of the current restrictive intervention(s);
3. designation of the interventions on a hierarchy of implementation, ranging from the most positive or least restrictive/intrusive to the least positive or most restrictive, for each challenging or maladaptive behavior being addressed;
4. a specific plan to minimize and/or fade the use of each restrictive intervention, eliminate the use of a restrictive intervention, and/or transition to the use of a less restrictive, more positive intervention;
5. a description of how each use of a restrictive intervention is to be documented and by whom; and
6. a schedule to review and analyze the frequency, duration and intensity of use of the restrictive intervention(s) included in the BMP. The results of this review must be documented and the information used to determine if and when revisions to the behavior management plan are needed.

A BMP incorporating the use of *restrictive physical interventions* (i.e. one or two person take-downs to side, seated, or supine control as defined in the OMRDD training curriculum) and/or use of *exclusionary time-out* (the placement of a person alone in a room from which his or her normal egress [ability to leave] is prevented by a staff's or care provider's direct and continuous physical action, or placement of a person in a secured room or area from which he or she cannot leave at will), is prohibited in IB Services.

Coordinating and Training of the BMP

Prior to implementation of a BMP written informed consent must be obtained from the Parent/Legal Guardian or other authorized consent-giver. The consent-giver shall have the right to revoke approval of the plan at any time, and request that a new BMP be developed in accordance with the requirements of this Appendix.

In addition, when BMPs are being utilized in more than one service setting, the agency should consult and coordinate with these other service settings in order to develop an appropriately integrated plan and prevent conflicting or inadvertently partially reinforcing strategies.

Parents/Caregivers, At Home Residential Habilitation (or Community Habilitation) staff, and Family Care providers responsible for the support and supervision of a person who has a BMP, should be trained by the IB Services provider in all aspects of that person's plan prior to implementation.

Parents/Caregivers, At Home Residential Habilitation (or Community Habilitation) staff, and Family Care providers responsible for the support and supervision of a person whose BMP

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includes the use of a restrictive intervention, shall be trained in the particular intervention(s) to be utilized with a specific person, prior to their use. If the BMP incorporates the use of protective and defensive physical interventions (*specified on page one of this document*), then training shall be in accordance with the standards and procedures of the OMRDD training curriculum. However, parents/caregivers, At Home Residential Habilitation (or Community Habilitation) staff, and Family Care providers will not be trained in restrictive physical interventions or use of *exclusionary* time-out as plans will not incorporate these interventions. *Parents/caregivers cannot be certified at any level of the OMRDD training curriculum and should only be taught those specific protective and defensive interventions (specified on page one of this document) identified in the BMP created for the person for whom they provide care.*

Nothing in this Appendix shall prevent the use of an emergency intervention by At Home Residential Habilitation (or Community Habilitation) staff and Family Care providers to prevent a person who is undergoing acute behavioral or emotional disturbance from seriously injuring him/herself or others. Emergency behavior management techniques to prevent or minimize injury shall be used only for as long as the duration of the incident. These events should be reported in accordance with Part 624.

Additional Practices

Agencies shall also establish a written agreement with individuals and/or families regarding the nature, duration and scope of IB services to be provided to the individual.

The FBA and BMP should be in written form and signed by the Licensed psychologist or Licensed Clinical Social Worker delivering IB Services or by both the non-licensed clinician delivering IB services and his/her licensed clinical supervisor if the non-licensed clinician was the staff person writing the FBA and/or BMP.

All training of parties responsible for implementation of the plan and any retraining when the BMP is modified should be appropriately documented.

Immediately after the use of any physical intervention (protective or defensive strategies, emergency interventions), staff shall visually examine the person for possible injury, and document the findings of such examination. At Home Residential Habilitation (or Community Habilitation) staff should report the results of their visual examination to their supervisor as soon as reasonably possible, and have the Parents/Caregivers co-sign the documentation completed by staff indicating their agreement with the results of the visual examination. If an injury is suspected, provision of an appropriate level of medical care shall be provided or arranged. Any injury that requires more than first aid must be reported in accordance with Part 624.

Every agency providing Intensive Behavior (IB) Services should develop behavior management policies and procedures that are in conformance with this Appendix.