Guidelines for Positive Supports in DHS-Licensed Settings

A Resource Manual for Minnesota's DHS-Licensed Providers for Developing Positive Support Strategies, Responding to Interfering Behavior and Developing Positive Support Transition Plans

Developed by the Disability Services Division of the Community Supports Administration of the Minnesota Department of Human Services

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Minnesota Department of Human Services

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Mission, Values and Goals of the Minnesota Department of Human Services

Minnesota Department of Human Services Mission

The Minnesota Department of Human Services, working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential.

Minnesota Department of Human Services Values

- We focus on people, not programs
- We provide ladders up and safety nets for the people we serve
- We work in partnership with others: we cannot do it alone
- We are accountable for results to the people we serve and all Minnesotans

Disability Services Division's "Domains of a Meaningful Life"

Community Membership;

Health, wellness and safety;

Own place to live;

Important Long-term relationships;

Control over supports, and;

Employment earnings and stable income.

Purpose

"Ensuring Minnesotans we care for are treated with respect and dignity is a key element of our agency's mission. Practices around seclusion and restraint have not always been consistent with these principles …To that end, it is our goal to prohibit procedures that cause pain, whether physical, emotional or psychological, and prohibit the use of seclusion and restraints for all programs and services licensed or certified by the department. It is our expectation that service providers will seek out and implement therapeutic interventions that reflect best practices."

> —DHS Respect and Dignity Practices Statement (PDF), DHS Commissioner L. Jesson, 2013

The Minnesota Department of Human Services (DHS) developed this manual for DHS-licensed providers to explain their duties under Minnesota Rule 9544, known as the Positive Supports Rule (PSR). The PSR governs the use of positive support strategies and restrictive interventions for DHS-license holders serving a person with a developmental disability or any person receiving a 245D-licensed service. In addition to explaining the requirements of the PSR, this manual attempts to offer guidance for teams developing positive support strategies. As recommended by an Advisory Committee[1], this manual draws heavily on *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings, A Resource Manual for Georgia's Community Programs Serving Persons with Serious and Persistent Mental Health Issues*. Much of the information in this manual is adapted from the Georgia Manual to comply with the unique laws of Minnesota.

The goal of any positive support strategy is to improve a person's quality of life. It does this by teaching the person skills or strategies that increase their ability to meet their own needs and thereby increase their autonomy. The PSR requires the creation of positive support strategies for every person covered by the rule. The PSR prohibits the use of many physical and behavioral interventions and requires the development of a Positive Support Transition Plan when the emergency use of a manual restraint occurs at a high frequency with a person (3 times or more in 90 days or 4 times or more in 180 days). The purpose of a Positive Support Transition Plan (PSTP) is to incorporate positive support strategies into a person's life to eliminate the use of aversive procedures, to avoid the emergency use of manual restraint, and to prevent the person from physically harming themselves or others.

The PSR supports several goals that represent the latest developments in the field of disability services. These goals include:

- Promote community participation, person-centeredness & inclusion in the most integrated setting
- Focus on creating quality environments
- Ensure collaborative development of positive support strategies
- Increase skills and self-determination of people receiving services
- Improve the quality of life of people receiving services
- Ensure people are free from humiliating and demeaning procedures
- Eliminate the use of aversive and deprivation procedures
- Create a consistent set of standards for providers across service settings

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[1] See Rule 40 Advisory Committee Recommendations on Best Practices and Modernization of Rule 40

Person-Centered Planning

Adapted from [Guidelines for Supporting Adults with Challenging Behaviors in Community Settings (PDF)](#)

Person-centered planning (PCP) is a collection of models that provide a way to get to know a person and their "story". This helps you know what they want in life, where they prefer to live, what makes them happy, and how to balance what is important for them with what is important to them. PCP is a planning process useful for all people, regardless of ability, that addresses all areas of their life, including community participation, relationships, work, and aspirations. It is a collaborative process to help people identify the supports and services they need to live a quality life based on their preferences and values. The person served drives the planning process and those who know the person best are important supporters in the planning process.

> **Person-centered planning: a strategy used to facilitate team-based plans for improving a person's quality of life as defined by the person, the person's family, and other members of the community, and that focuses on the person's preferences, talents, dreams and goals. It is part of a family of approaches to organizing and guiding community change in alliance with the people with disabilities and their families and friends**
>
> **MN Rule 9544.0020, subp. 38**

PCP is a shift from the old treatment paradigm of creating goals and plans *for* a person. In the past, many plans focused on a person's weaknesses and created treatments and supports to address these weaknesses. Old plans often focused only on what was important *for* a person (e.g., their health and safety). First and foremost, PCP seeks to create plans *with* a person and focus on what is important *to* them, attention to what is important *for* them, and the creation of a balance between these two. Balance can be achieved by using what is important TO a person as context to address what's important FOR them. Old plans used a 'readiness model' where fully addressing important FOR was prerequisite to addressing important TO (e.g., once the person stops touching others he can seek the community employment he wants). Now we think of that supported job as the right context in which to address and expect a lower rate of touching.

The PCP process starts with listening to the person and honoring their vision. A person-centered approach asks us to remember people as whole human beings with dreams, hopes, preferences, and desires like everyone else. Support and encouragement is required in order to realize their wishes and potential. Person-centered planning focuses on identifying and maximizing the strengths and preferences rather than creating lists of what the person cannot do.

A person-centered approach for developing positive support strategies is similar in that it requires listening to the person to gain an understanding of who the person is, the person's wishes and hopes for his or her life, honoring his/her vision, understanding his or her strengths and challenges, and giving consideration to the context of his or her social and environmental setting, including any relevant medical or psychiatric conditions. It requires listening to the person through their words and actions so that the meaning and significance of their behavior(s) can be understood. Person-centered planning informs and contributes to the development of positive support plans that lead to improvements in the person's quality of life, acquisition of valued skills, and access to desired settings, activities and people. [Appendix E](#) provides more information about the Art of Authentic Person-Centered Planning.

When using a person-centered approach, it is most important to identify the gaps between the person's life and how he/she wants his/her life to be. The person-centered planning process may include strategies for minimizing

situations that cause stress for the person and maximizing the person's control over their life. Some essential characteristics of person-centered planning, adapted from Eber and Nelson (1997) and Kincaid and Fox (2002) are:

- People are encouraged to direct their own meetings and select team members
- Meeting length, location, and processes are organized to meet the preferences of each person
- Assessment and goal development focus on strengths and team-based problem solving
- The team identifies natural supports, rather than over-relying on existing services
- Strategies focus on community-based supports that help people make important contributions to their communities
- Choice making and opportunities for self-expression and self-determination are embedded in planning meetings
- Goals include creating steps for creating a positive future and are based on the person's preferences, interests
- Interagency collaboration is a valued process, with attention placed on streamlining supports
- Supports are provided to the person in an unconditional manner
- Developing and maintaining significant relationships with others are important considerations in planning processes

Appendix F and Appendix G provide examples of person-centered questionnaires/assessments.

Overview of Person-Centered Planning Requirements

PCP is not only a good idea; it is required by the PSR and 245D. An overview of the requirements are as follows:

1. License holders must incorporate principles of person-centeredness in services it provides to a person. This means:
    a. Identifying and incorporating what is important to as well as what is important for the person into supports
    b. Using information to identify outcomes the person desires
    c. Respecting each person's history, dignity and cultural background
    d. Supporting the person's self-determination by providing:
        i. Opportunities for the development and exercise of age-appropriate skills, decision making and choice, personal advocacy and communication
        ii. Affirming the protection of each person's civil and legal rights, and
    e. Providing the most integrated setting and inclusive service delivery that supports, promotes and allows:
        i. Inclusion and participation in one's own community as desired by the person in a manner that enables the person to interact with nondisabled persons to the fullest extent possible
        ii. Opportunities for self-sufficiency as well as developing and maintaining social relationships and natural supports, and
        iii. A balance between risk and opportunity, meaning the least restrictive supports or interventions necessary are provided in the most integrated settings in the most inclusive manner possible to support the person to engage in activities of their own choosing that may otherwise present a risk to the person's health, safety, or rights.
2. License holders must evaluate every six months with the person whether the services support the person's preferences, daily needs, activities and the accomplishment of the person's goals in accordance

with Minnesota Statutes, section 245D.07, subdivision 1a, paragraph (b) and whether the person-centered planning process complies with Code of Federal Regulations, title 42, section 441.725, paragraph (a)(1)-(4). Based upon the results of the evaluation, the license holder must determine whether changes are needed to enhance person-centeredness for the person, and, if so, make appropriate changes.

NOTE TO LEAD AGENCY STAFF: DHS released a [Person-Centered, Informed Choice and Transition Protocol (PDF)](#) in 2016 to communicate expectations regarding person-centered planning with its lead agency partners. The protocol addresses federal and state statutes, rules and court requirements related to person-centered principles and practices. While directed towards lead agencies, providers and persons receiving supports and services may find reviewing the protocol helpful to understand DHS expectations.

Understanding Behavior

Adapted from [Guidelines for Supporting Adults with Challenging Behaviors in Community Settings (PDF)](#)

What is behavior?

Behavior is what we all do. It includes observable actions such as smiling, talking, eating and dressing. Everybody "behaves" almost all the time.

Different situations or environments have different rules or expectations about how to behave. For example, behavioral expectations are different in a library than at a ball game. These beliefs about what is expected may differ with each person. When someone does not understand these expectations or fails to conform to them, his/her behavior may limit the opportunity for success, participation, status and friendship. These types of behaviors are called **interfering behaviors** in the PSR. "Interfering behavior" goes by many names outside of the PSR, such as "challenging", "dangerous", "problem" or "difficult" behavior.

> **Interfering behavior: a behavior or psychiatric symptom that prevents a person from engaging in a more integrated setting or from participation in the most integrated setting**
>
> **MN Rule 9544.0020, subp. 23**

Interfering behaviors vary in seriousness and intensity. Interfering behavior can vary depending on what is accepted by the person, a community or a society. Interfering behaviors are often self-defeating in that their occurrence often prevents a person from accomplishing their desired outcomes for their life. For instance, if a person becomes aggressive because they cannot go to a movie at a specific time (for whatever reason), they are even less likely to go in the near future due to safety concerns.

What influences behavior?

Behavior is related to many things. It always has a purpose or a function. This does not mean that the behavior is voluntary or used consciously. Examples of purpose and function are getting something, avoiding something undesirable or enjoying something.

Some behaviors, like unexplained movements or sounds, can be neurologically based and cannot be changed with behavioral interventions. These behaviors often just "seem to happen". While the person has no control over these behaviors, sometimes the person or staff find that certain stimuli in the environment may trigger their occurrence.

Behavior is influenced by what the person is experiencing or has experienced. Factors that influence a particular behavior can come from any of these sources:

- **Physiological** (from within the physical part of us)
- **Social** (from any situation involving all people we have ever encountered including cultural, ethnic or linguistic background)
- **Psychological** (from emotions, feelings or thought processes)
- **Environmental** (from any part of our surroundings)

Some examples of internal and external sources just listed are:

1. **Physiological** - such as feeling full or satisfied, feeling pain, having skips in your heart [that can mean you have less oxygen to the brain], low blood sugar so you feel really hungry and can't think, needing to go to the bathroom, neurological issues, car or motion sickness, physical or mental/cognitive disabilities, etc.

2. **Social** - such as seeing a face that reminds you of someone you do not like, going to a party, seeing the same faces day after day, sitting in church, going to a movie, being at a dance, social rejection, social isolation, discrimination, etc.

3. **Psychological** - such as an angry response to a particular word, hearing someone laugh when we don't understand why, being called a name, being given a compliment, feeling frustrated because things are not as you want them to be, thinking about something nice that happened, feeling bored about the same routine, or feeling scared of something new, etc.

4. **Environmental** - such as a dark corner, a rainstorm, a beautiful garden, a hot sultry day, a car horn blowing, coffee brewing, etc.

While what is going on inside our bodies is hard to see, behavior can be observed and described. However, remember to consider what might be going on inside. Most people would find it difficult to concentrate if they had to go to the bathroom, had a toothache, were incredibly thirsty, and were hearing voices telling them what to do or they had a fight with a family member before coming to work.

Too often, we jump to behavior programs as soon as an interfering behavior is present. First, we need to ask the question **"What is the person's behavior communicating to us?"** Table 1.1 has **many examples** of physiological, environmental, psychological or social issues that may be affecting a person's behavior.

Table 1: Factors that may affect a person's behavior

BEHAVIORAL OR PHYSIOLOGICAL INFLUENCES	ENVIRONMENTAL	PSYCHOLOGICAL	SOCIAL
Allergies	Air quality	Anxiety	Being stared at
Anticipatory pain	Close proximity to others	Apprehension	Change in staff
Arthritis	Humidity	Dementia	Criticism
Attention deficit	Lighting	Fear	Danger
Constipation	Limited physical space	Hallucinations	Demands
Delusions	Noise	How thoughts are processed	Disapproval
Dementia	Smells	Loneliness	Discrimination
Ear aches	Temperature	Phobias	Disruption by others
Energy – too much	Uncomfortable furniture	Personality traits	Frequent change
Energy – too little	Trauma triggers	Sex drive	Lack of social attention
Fractures	**And many more possibilities!**	Shyness	Not having choices Presence of specific person(s)
Headaches		Submissiveness	Relocation
Hallucinations		Suspiciousness	Sexual provocation
Hunger		Vengeance	Teasing by others
Itching		Worry	Tone of voice
Medication reactions		**And many more possibilities!**	Too little to do
Medication side effects			Too much to do
Pain			**And many more possibilities!**
Premenstrual syndrome			
Seizures			
Sex drive			
Substance Intoxication			
Substance Use			
Substance Withdrawal			
Thirst			
Tobacco craving			
And many more possibilities!			

How do we figure out what is influencing the interfering behavior?

Medical and psychiatric conditions have been found to play a direct role in influencing interfering behaviors. This is especially true for persons who communicate in ways that are not familiar to us or are non-vocal. Is the person constipated? [This is a very common side effect of certain medications or not having enough fluids, fruits or vegetables]. Is the person taking their medication for the voices they hear? [Often people will say that the side effects of the medication are worse than hearing what the voices tell them to do]. Does the person have an infection? [How would you know when this is true?].

A second and similarly important consideration is that interfering behaviors are influenced by being lonely, being on the outside looking in. Again, this is especially true for persons who do not use words to communicate. Is the quality of the person's life acceptable (in their opinion)? Do relationships exist in the person's life that support choice and maximize social and personal skills? Are the relationships between staff and the person appropriate

from a professional perspective? Does the person have opportunities for involvement in the community that would support personal social relationships?

There is a HUGE difference between developing a friendship with a person and simply being with that person because it is your job. If our professional interventions do not lead to a meaningful life and personal relationships with unpaid people for a person, what have we accomplished? (Ryan, 1999)

When trying to understand the reasons an interfering behavior occurs, it is also important to recognize the role other factors may play, such as:

1. Skill deficits such as underdeveloped stress management, coping and negotiation skills
2. Vulnerability to poor role models (e.g., my parents hit me, so why can't I hit other people?)
3. Fewer life experiences that help people understand how the world works or how others may perceive it
4. Higher levels of stress from being unable to predict and plan for future events or understand reasons for things (e.g., there is an ice storm so my daily schedule is messed up)

Finally, in instances where a Positive Support Transition Plan (PSTP) is required, a Functional Behavior Assessment (FBA) takes an in-depth look at what factors may play a role in the incidence of an interfering behavior. The FBA has three results:

1. A firm definition of the interfering behavior(s) so that it can be recognized and recorded by all people working with the person;
2. Descriptions of situations in which the interfering behavior(s) is likely to occur and not occur; and
3. At least one hypothesis of why the interfering behavior occurs that directly informs the PSTP.

After the FBA is complete, the PSR considers the former interfering behavior to now be a *target behavior*. PSTPs, FBAs and target behaviors are explained in depth shortly.

Focus first on possible physical or mental health issues

We do not usually look at medical or psychiatric issues or personal satisfaction as reasons for interfering behaviors. Instead we get frustrated and say, "they are just being a pain" or "she's just that way'". Sometimes caregivers get frustrated to the point of acting or reacting in ways that make things worse. The interfering behaviors of the person coupled with our reaction can become a downward spiral.

However, looking at medical or psychiatric issues is imperative. One expert in the Developmental Disability field who works with persons with interfering behaviors said, "Until proven wrong, my first assumption is that part of the body hurts. Until we help the person feel better, the behavior will not stop. If the person is in pain, they have two choices: 1) the pain controls me; or 2) I control the pain. The behavior is a form of intentional communication."

As further illustration, in the state of Massachusetts a hospital psychiatric unit was set up to work with people with DD who had very difficult interfering behaviors. They were taken to the psychiatric unit when the "cause" of the interfering behavior could not be figured out in the community. In that psychiatric unit, it was documented that over 75% of issues determined to be "causing" interfering behaviors had an underlying medical in origin, such as chronic infection, enlarged prostate, etc.

For persons with mental health issues, interfering behaviors often result from internal physiological or psychological stimuli that cannot be tolerated, or from misperception of social or environmental situations.

We owe it to the person served and to ourselves to figure out what the behavior is communicating. Here are some questions to keep in mind while analyzing what is causing complex, interfering behaviors:

1. **Is the behavior a symptom of a medical disorder?** For example, a person with a neurological disorder may strike out when becoming excited due to involuntary movements or poor muscular control.

2. **Is the quality of the person's life acceptable** (in their opinion) **in terms of personal relationships, personal choices or living situation, etc.?**

3. **Is the behavior influenced by medications they are taking (intended effects, side effects, etc.)?** For example, taking an anticholinergic that results in an increase in pacing and leg movements, which can resemble anxiety.

4. **Is the behavior part of a cluster or chain of related behaviors?** For example, if a person does not want to go to work, the person may use several behaviors to keep from going, such as refusing to get up, pretending to be sick, running away or attacking others. If so, one intervention may solve many challenges. If not, priorities will have to be set because trying to change many different behaviors at the same time is likely to cause confusion and reduce the chance for success.

5. **Is the behavior influenced by a lack of a skill or skills?** Often interfering behaviors occur because of a missing skill. If a person is asked to do something that he or she does not understand or is unable to do, the person may become frustrated and strike out or hurt him or herself to make the demand go away. Similarly, a person who hasn't developed coping skills may have difficulty handling stressful situations.

6. **Is the behavior a part of their behavioral phenotype**? A "behavioral phenotype" refers to a pattern of behavior, learning, or a personality trait typically seen among people with a specific genetic condition. For example, people are generally aware that persons with Down syndrome have a characteristic appearance, but people with Down syndrome also have a characteristic personality, socially approaching other people more than is common, and also a characteristic learning pattern with auditory short-term memory challenges. Those are the behavioral phenotypes associated with Down syndrome. There are many other behavioral phenotypes associated with other Intellectual or Developmental Disabilities, and these are important to recognize because they may contribute to challenging behavior and they are very difficult to change. People with Fetal Alcohol Syndrome or Fetal Alcohol Effects have trouble learning cause-and-effect relationships and get sensory overload more than typical people. People with Williams syndrome often have highly developed conversational skills and express sympathy and concern for other people, which is not always welcomed by strangers. People with Angelman syndrome have extremely high levels of motor activity and often have a happy facial expression, even during problem behavior, which can be misinterpreted. Learn about a person's genetic condition and how it may be expressed behaviorally. Understand that a behavioral phenotype may be difficult to change.

7. **Does this person have a history of traumatic experiences**? Trauma can result from being sent to your room too often, bullying or teasing from others, corporal punishment, abuse or neglect and many other

factors (see the Adverse Childhood Experiences literature for more information). Trauma can cause emotional damage, hypervigilance, an inability to connect with people, and other psychiatric issues. The most well known result of traumatic experiences is Post Traumatic Stress Disorder (PTSD). PTSD can be difficult to identify without a thorough study of the person's history.

In summary, be certain to ask these questions:

1. **What does the behavior get for the person?** W**hat is experienced as positive is entirely in the eyes of the beholder. The same goes for what is experienced as negative.** For example, some people enjoy attention of any kind! Some people prefer to be quiet and alone. Behavior that results in a change that the person perceives as positive in some way is likely to be repeated. Therefore it is important to give people choice as a form of personal control.
2. **What does the behavior help the person escape?** For example, if hitting others who are making too much noise results in being sent away from the noise, this could be what works for the person.
3. **What does the behavior help the person avoid?** For example, playing sick may result in getting to stay home from school, which may be a very stressful place.

Table 2 provides a list of common interfering behaviors along with probable biological causes. Pain is often a very real cause of interfering behaviors. Look at Appendix B.1 for excellent ideas to consider about pain being the source of the interfering behavior. Appendix B.2 then provides an extensive list of other medical issues to consider. Be sure to look at both of these for additional ideas.

Table 2: Common interfering behaviors and speculations about their causes

BEHAVIOR	EXAMPLES OF SUSPECTED BIOLOGICAL CAUSE
Biting side of hand/whole mouth	• Sinus problems • Ears/Eustachian tubes • Eruption of wisdom teeth • Dental problems • Paresthesia/painful sensations (e.g., pins & needles) in the hand
Biting thumbs/objects with front teeth	• Sinus problems • Ears/Eustachian tubes
Biting with back teeth	• Dental • Otitis (ear)
Fist jammed in mouth/down throat	• Gastroesophageal reflux • Eruption of teeth • Asthma • Rumination • Nausea
General Scratching	• Eczema • Drug effects • Liver/renal disorders • Scabies • Bed bugs
Head Banging	• Pain • Depression • Migraine • Dental • Seizure • Otitis (ear ache) • Mastoiditis (inflammation of bone behind the ear)

BEHAVIOR	EXAMPLES OF SUSPECTED BIOLOGICAL CAUSE
	• Sinus problems • Tinea capitis (fungal infection in the head) • Hearing internal voices
Intense rocking/preoccupied look	• Visceral pain • Headaches • Depression • Dissociative Disorder
Odd un-pleasant masturbation	• Prostatitis • Urinary tract infection • Candida vagina • Pinworms • Repetition phenomena, PTSD
Pica – ingesting inedibles	• General: OCD, hypothalamic problems, history of under-stimulating environments • Cigarette butts: nicotine addiction, generalized anxiety disorder • Glass: suicidality • Paint chips: lead intoxication • Sticks, rocks, other jagged objects: endogenous opiate addiction • Dirt: iron or other deficiency state • Feces: PTSD, psychosis
Scratching/hugging chest	• Asthma • Pneumonia • Gastroesophageal reflux • Costochondritis/"slipped rib syndrome" • Angina
Scratching stomach	• Gastritis • Ulcer • Pancreatitis (also pulling at back) • Porphyria (bile pigment that causes, among other things, skin disorders) • Gall bladder disease
Self-restraint/binding	• Pain • Tic or other movement disorder • Seizures • Severe sensory integration deficits • PTSD • Paresthesia
Stretched forward	• Gastroesophageal reflux • Hip/back pain • Back pain
Sudden sitting down	• Atlantoaxial dislocation (dislocation between the vertebrae in the neck) • Cardiac problems • Seizures • Syncope/orthostasis (fainting or light-headedness caused by medications or other physical conditions) • Vertigo • Otitis (thrown off balance by problems in the ear)
Uneven seat	• Hip pain • Genital discomfort • Rectal discomfort

BEHAVIOR	EXAMPLES OF SUSPECTED BIOLOGICAL CAUSE
Walking on toes	• Arthritis in ankles, feet, hips or knees • Tight heel cords
Waving fingers in front of the eyes	• Migraine • Cataract • Seizure • Rubbing caused by blepharitis (inflammation of the eyelid) or corneal abrasion
Waving head side to side	• Declining peripheral vision or • Reliance on peripheral vision
Whipping head forward	• Atlantoaxial dislocation (dislocation between the vertebrae in the neck) • Pain in hands/arthritis
Won't sit	• Akathisia (inner feeling of restlessness) • Back pain • Rectal problem • Anxiety disorder

For more information about recognizing signs of drug use of intoxification, visit the Mayo Clinic website: http://www.mayoclinic.org/diseases-conditions/drug-addiction/basics/symptoms/con-20020970

When does an interfering behavior become a target behavior?

For some, the definition of "target behavior" in the PSR may differ from the definition they have used elsewhere. The term "target behavior" is used by some professionals to specify *any* behavior that is targeted for change; either an increase or decrease in frequency. For the purposes of the Positive Supports Rule, a target behavior refers *only* to a behavior identified in an individual written plan for reduction or elimination.

The only time the PSR requires a team to convert an interfering to a target behavior is during the creation or revision of a Positive Support Transition Plan (PSTP). When an interfering behavior is identified for reduction and/or elimination, it then becomes a target behavior. A qualified professional defines the interfering behavior during the functional behavior assessment – which is required during the development and/or revision of a PSTP. More information about the PSTP, qualified professionals and functional behavior assessments are included later in this guide.

> *Target behavior: an observable behavior identified in a person's individual plan as the object of efforts intended to reduce or eliminate the behavior.*
>
> *MN Rule 9544.0020, subp. 54*

Supporting people in positive ways: developing positive support strategies

Adapted from [Guidelines for Supporting Adults with Challenging Behaviors in Community Settings (PDF)](#)

> **Positive support strategy: a strengths-based strategy based on an individualized assessment that emphasizes teaching a person productive and self-determined skills or alternative strategies and behaviors without the use of restrictive interventions.**
>
> **MN Rule 9544.0020, subp. 41**

Regardless of the challenges presented by a person, we can all support them in positive ways. In fact, the PSR requires the development and implementation of positive support strategies for every person[2]. This might sound like a lot of work, but you probably already use these approaches and do not know that they are considered "positive support strategies".

While some may argue that the PSR prohibits many of the interventions they have used to maintain safety, the most effective intervention is still available: increase the person's quality of life. Evidence shows that people who experience a higher quality of life exhibit fewer interfering behaviors. People who are happy with their job, their living situation and the people with whom they associate are less likely to exhibit interfering behaviors and have decreased severity of mental illness symptoms. The use of positive support strategies are proactive interventions that improve a person's quality of life. They create an environment less likely to contribute to interfering behavior.

Many treatment models have shifted focus to consider quality of life as the highest priority that, when successfully addressed, leads to reduced symptoms and behaviors. Reforms to Minnesota Law found in the PSR and 245D reflect this change. While there are many models for gauging quality of life, one of the factors reported to contribute to enhanced quality of life is the feeling of being in control or autonomy. (Connell, Brazier, O'Cathain, Lloyd-Jones & Paisley, 2012). Increasing or maintaining a person's autonomy is the primary goal of a positive support strategy.

Teaching Skills: General Positive Support Strategies

The goal of many services for people receiving services is to offer habilitation or re-habilitation. "Habilitation" means to "make fit or capable". In other words, it means to teach or re-teach skills. Therefore, while the introduction of "positive support strategies" as a requirement may seem like a major shift in service philosophy, it really is not. In a person-centered context, there are plans for people to access what is important to them through supports and through learning. Positive support strategies teach skills. They do this by developing strengths-based strategies from an individual assessment to teach a person self-determined skills or alternative strategies and behaviors without the use of restrictive interventions. In essence, a positive support strategy must:

1. Be strengths-based
2. Be culturally and linguistically competent/responsive to needs
3. Have focus on individual preference and choice
4. Be developed from an individualized assessment
5. Teach skills and/or strategies that aide in their autonomy
6. Not include a restrictive intervention

Service providers most often work to increase the functioning, independence and autonomy of the people they support. Positive support strategies now reflect best practice for accomplishing that task.

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[2] Minnesota Rules, section 9544.0030, subpart 1

The reason is simple: punishment and restrictive interventions do not teach skills. These techniques teach a person what *not* to do; what behaviors they should avoid if they do not want to be punished. Punishment, while once considered an appropriate component of teaching and training, has been found to have many more pitfalls than pluses, such as:

- Restrictive and intrusive interventions, once implemented, may remain in place longer than needed (Iwata, Rolider and Dozier, 2009)
- Use of punishment can violate ethical standards and laws
- Reductions in target behaviors learned may not transfer to settings outside of the area punishment is used (Lerman & Vorndran, 2002)
- Punishment can be shaming and dehumanizing (Lerman & Vorndran, 2002)
- The use of punishment has the potential for abuses by caregivers/therapists (Vollmer, 2002)
- Punishment can escalate interfering behavior or create new, unwanted behavior (Mazur, 2002, Spradlin, 2002)
- Prior experience with punishing stimuli can decrease sensitivity to that punishment (Lerman & Vorndran, 2002). This means that to be effective, intensity of punishment must increase to maintain the same behavior
- Punishment arouses emotion in both the punisher and the punished. The punisher may feel excited, satisfied or more aggressive impulses – which may cause the punisher to get carried away. The punished may feel pain, discomfort or humiliation, fear, hate, a desire to escape or self-contempt – emotions which may be counterproductive to the situation and/or relationship (Funder, 2004)
- Punishment teaches about power and control. It can teach that powerful people get to hurt less-powerful people. For this reason, it has been found that parents who were abused as children may become child abusers themselves (Carter, 1994; Funder, 2004; Hemenway, Solnick & Widom, 1989)
- Many interfering behaviors and symptoms are the result of trauma experiences. The use of punishment to change behavior adds to the person's trauma history. Rather than further traumatizing people who have histories of trauma, we need to provide them with therapy and healing environments.

For these reasons, DHS determined that licensed services for a person with a developmental disability or related condition or any person receiving a home and community-based service are not to experience punishment and restrictive interventions.

This, if anything, is the major change the PSR, along with portions of 245D, has brought to the service industry. For some, this is not a change because they already use positive support strategies and refrain from using restrictive interventions. For others, the use of punishment techniques may be ingrained in their own behavioral repertoire because it was used with them personally and was shown to be effective for gaining immediate compliance.

So, how do we support people to reduce behavior and achieve the life they want without the use of restrictive interventions? Many techniques have been shown to be effective for teaching skills. The PSR requires that professional standards be used. The PSR even lists a number of resources available to choose from when identifying professional standards for positive support strategies. They are:

A. The Association for Positive Behavior Support Standards of Practice
   a. www.apbs.org
B. The United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-Based Programs and Practices

a. http://nrepp.samhsa.gov/01_landing.aspx
C. SAMHSA Roadmap to Seclusion and Restraint Free Mental Health Services (PDF)
a. http://www.asca.net/system/assets/attachments/2661/Roadmap_Seclusion.pdf?1301083296
D. The Behavior Analyst Certification Board Guidelines for Responsible Conduct for Behavior Analysts
a. http://bacb.com/ethics-code/
E. The NADD Competency-Based Clinical Certification Program Competency Standard 1: Positive Behavior Support and Effective Environments
a. http://acp.thenadd.org/ccp.htm
F. Other standards approved by the commissioner that:
a. Have been peer reviewed;
b. Are widely accepted as authoritative; and
c. Reflect current best practices

Every person and the needs of the person is unique. You may need to look through all the above resources and others to find strategies that best fit the situation with which you are working. Appendix C and Appendix D contain even more resources you may consider when searching for appropriate positive support strategies.

Understanding Behavior Interventions

Sometimes our best efforts to improve the quality of life of the people we serve fail. Crises happen. While thorough, competent person-centered planning and practices can minimize crises, external or internal events can cause people to come into conflict. At these times, staff persons must also protect the health and safety of all people he or she supports. For the purposes of the PSR and 245D, "Behavior Interventions" are staff responses (interventions) to situations in which a person is in imminent danger of harming herself/himself or others.

The PSR, in combination with 245D, governs three types of behavior interventions: prohibited, restricted and permitted. The next section will provide more information on these interventions.

Prohibited interventions

According to the PSR, there are two classes of prohibited interventions: General and specifically prohibited. "General" prohibitions are those interventions prohibited under Minnesota Statute 245D. "Specifically" prohibited interventions are found in the PSR.

General prohibitions (from 245D)

Some of the terms used here hold different meanings in different professions/regions/etc. For that purpose, the definition from 245D will be used here to ensure the prohibition is understood.

Minnesota Statutes, section 245D.06, subdivision 5 prohibits license holders from using chemical restraints, mechanical restraints, manual restraints, time out, seclusion, or any other aversive or deprivation procedure, as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience.

Chemical restraint

Chemical restrain means the administration of a drug or medication to control the person's behavior or restrict the person's freedom of movement and is not a standard treatment or dosage for the person's medical or psychiatric condition.

Mechanical restraint

Mechanical restraint means the use of devices, materials, or equipment attached or adjacent to the person's body, or the use of practices that are intended to restrict freedom of movement or normal access to one's body or body parts, or limits a person's voluntary movement or holds a person immobile as an intervention precipitated by a person's behavior. The term applies to the use of mechanical restraint used to prevent injury with persons who engage in self-injurious behaviors, such as head-banging, gouging, or other actions resulting in tissue damage that have caused or could cause medical problems resulting from the self-injury. "Mechanical restraint" does not include devices worn by the person that trigger electronic alarms to warn staff that a person is leaving a room or area, which do not, in and of themselves, restrict freedom of movement. Nor does it mean the use of adaptive aids or equipment or orthotic devices ordered by a health care professional used to treat or manage a medical condition. Mechanical restraint includes use of an auxiliary device to ensure a person does not unfasten a seat belt in a vehicle. Mechanical restraint does not include:

- Use of a seat belt under Minnesota Statutes, section 169.686; or

- Use of a child passenger restraint system as required by Minnesota Statutes, section 245A.018, subdivision 1.

Manual restraint

Manual restrain means physical intervention intended to hold a person immobile or limit a person's voluntary movement by using body contact as the only source of physical restraint. Please note that "manual restraint" and the "emergency use of manual restraint" are defined separately and classified differently by 245D. See "restricted interventions" below for more information about the emergency use of manual restraint.

Time out

Time out means the involuntary removal of a person for a period of time to a designated area from which the person is not prevented from leaving. For the purpose of this chapter, "time out" does not mean voluntary removal or self-removal for the purpose of calming, prevention of escalation, or de-escalation of behavior; nor does it mean taking a brief break or rest from an activity for the purpose of providing the person an opportunity to regain self-control. "Time out" is a term used very differently among professions and regions. Behavior analysts refer to the version of time out prohibited under the rule as "time out from positive reinforcement" and in psychiatric hospital settings, this is referred to as a seclusion. This is very different from taking a break from a challenging situation or taking a break to regroup or collect oneself. For more information on time out, see Appendix N.

Seclusion

Seclusion means: (1) removing a person involuntarily to a room from which exit is prohibited by a staff person or a mechanism such as a lock, a device, or an object positioned to hold the door closed or otherwise prevent the person from leaving the room; or (2) otherwise involuntarily removing or separating a person from an area, activity, situation, or social contact with others and blocking or preventing the person's return.

Time out and seclusion are often confused. The key distinction between the two procedures is whether the person has the ability to exit when he/she has been involuntarily removed. Seclusion does not allow the person to exit that area while time out does.

Aversive procedure

Aversive procedure means the application of an aversive stimulus contingent upon the occurrence of a behavior for the purposes of reducing or eliminating the behavior. "Aversive stimulus" is defined as an object, event, or situation that is presented immediately following a behavior in an attempt to suppress the behavior. Typically, an aversive stimulus is unpleasant and penalizes or confines. An example of an aversive procedure is spraying a person with water mist (if the person finds it unpleasant) when they perform an interfering behavior. The intention of this procedure is to stop or decrease a behavior.

Deprivation procedure

Deprivation procedure means the removal of a positive reinforcer following a response resulting in, or intended to result in, a decrease in the frequency, duration, or intensity of that response. Oftentimes the

positive reinforcer available is goods, services, or activities to which the person is <u>normally entitled</u>. The removal is often in the form of a delay or postponement of the positive reinforcer. An example of a deprivation procedure is taking away a favored item or an outing when the person performs an interfering behavior. Removing levels or tokens that a person has achieved or received are other forms of deprivation procedures.

A license holder may not use any of the procedures listed above unless it meets all of the following conditions:
1. The procedure was used prior to the statute/rule effective date, or prior to admissions to a DHS-licensed program
2. The person and their team determine that the procedure cannot be ceased immediately and
3. The procedure is included in a Positive Support Transition Plan (PSTP). PSTPs are described later in this guide.

Please note that under no condition is the use of prone restraint authorized. "Prone restraint" is defined as the "use of manual restraint that places a person in a face-down position. Prone restraint does not include brief physical holding of a person who, during an emergency use of manual restraint, rolls into a prone position, if the person is restored to a standing, sitting, or side-lying position as quickly as possible (245D.06, subd. 6, paragraph (b) item (7)). Data on the use of restraint found a majority of fatalities occurred due to the use of prone restraint. For more information on the dangers of prone restraint, please see [The Lethal Hazard of Prone Restraint: Positional Asphyxiation (PDF)](http://www.disabilityrightsca.org/pubs/701801.pdf) (http://www.disabilityrightsca.org/pubs/701801.pdf).

> **Prone Restraint: Prohibited under any conditions, prone restraint is the use of manual restraint that places a person in a face-down position**

Specifically prohibited interventions
The PSR specifically prohibits the following interventions:

A. using prone restraint, metal handcuffs, or leg hobbles;
B. using faradic shock;
C. speaking to a person in a manner that ridicules, demeans, threatens, or is abusive;
D. using physical intimidation or a show of force;
E. containing, restricting, isolating, secluding, or otherwise removing a person from normal activities when it is medically contraindicated or without monitoring the person;
F. denying or restricting a person's access to equipment and devices such as walkers, wheelchairs, hearing aids, and communication boards that facilitate the person's functioning. When the temporary removal of the equipment or device is necessary to prevent injury to the person or others or serious damage to the equipment or device, the equipment or device must be returned to the person as soon as imminent risk of injury or serious damage has passed;
G. using painful techniques, including intentional infliction of pain or injury, intentional infliction of fear of pain or injury, dehumanization, and degradation;
H. hyperextending or twisting a person's body parts;
I. tripping or pushing a person;
J. using punishment of any kind;
K. requiring a person to assume and maintain a specified physical position or posture;
L. using forced exercise;
M. totally or partially restricting a person's senses;
N. presenting intense sounds, lights, or other sensory stimuli;

O. using a noxious smell, taste, substance, or spray, including water mist;
P. depriving a person of or restricting access to normal goods and services, or requiring a person to earn normal goods and services;
Q. using token reinforcement programs or level programs that include a response cost or negative punishment component;
R. using a person receiving services to discipline another person receiving services;
S. using an action or procedure which is medically or psychologically contraindicated;
T. using an action or procedure that might restrict or obstruct a person's airway or impair breathing, including techniques whereby individuals use their hands or body to place pressure on a person's head, neck, back, chest, abdomen, or joints;
U. interfering with a person's legal rights, except as allowed by Minnesota Statutes, section 245D.04, subdivision 3, paragraph (c). For purposes of this item, "legal rights" means rights afforded in federal regulation or state licensing standards governing the program;
V. mechanical restraint, in accordance with Minnesota Statutes, section 245D.06, subdivision 5;
W. chemical restraint, in accordance with Minnesota Statutes, section 245D.06, subdivision 5;
X. manual restraint, except in an emergency in accordance with Minnesota Statutes, section 245D.061; and
Y. using any other interventions or procedures that may constitute an aversive or deprivation procedure.

Restricted interventions

The following procedures are allowed when the procedure is implemented in compliance with standards in the PSR/245D:

1. Permitted actions and procedures subject to the requirements in 245D.06, subdivision 7;
2. Procedures identified in a Positive Support Transition Plan subject to the requirements in Minnesota Statutes, 245D.06, subdivision 8; or
3. Emergency use of manual restraint subject to the requirements in Minnesota Statutes, section 245D.061.

"Emergency use of manual restraint" or EUMR

EUMR is defined as using a manual restraint when a person poses an imminent risk of physical harm to self or others and the EUMR is the least restrictive intervention that would achieve safety. Property damage, verbal aggression, or a person's refusal to receive or participate in treatment or programming on their own do not constitute an emergency. While EUMR is allowed in an emergency, there are restrictions surrounding its use.

Emergency use of manual restraint must meet both of the following conditions:

1. Immediate intervention must be needed to protect the person or others from imminent risk of physical harm, **and**
2. The type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety. The manual restraint must end when the threat of harm ends.

All license holders must have a policy regarding the use of EUMR that specifies each of the following:

1. A description of the positive support strategies and preventive techniques staff must use to attempt to de-escalate a person's behavior before it poses an imminent risk of physical harm to self or others
2. A description of the types of manual restraints the license holder allows staff to use on an emergency basis, if any. If the license holder will not allow the emergency use of manual restraint, the policy and

procedure must identify the alternative measures the license holder will require staff to use in emergency situations when a person's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety

3. Instructions for safe and correct implementation of the allowed manual restraint procedures
4. The training that staff must complete and the timelines for completion, before they may implement an emergency use of manual restraint. In addition to the training on this policy and procedure and the orientation and annual training required in section 245D.09, subdivision 4, the training for emergency use of manual restraint must incorporate all of the following subjects:
    a. Alternatives to manual restraint procedures, including techniques to identify events and environmental factors that may escalate conduct which poses an imminent risk of physical harm to self or others
    b. De-escalation methods, positive support strategies, and how to avoid power struggles
    c. Simulated experiences of administering and receiving manual restraint procedures allowed by the license holder on an emergency basis
    d. How to properly identify thresholds for implementing and ceasing restrictive procedures
    e. How to recognize, monitor, and respond to the person's physical signs of distress, including positional asphyxia
    f. The physiological and psychological impact on the person and the staff when restrictive procedures are used
    g. The communicative intent of behaviors **and**
    h. Trust and relationship building with the person
5. The procedures and forms to be used to monitor the emergency use of manual restraints, including what must be monitored and the frequency of monitoring for each incident of emergency use of manual restraint, and the person or position who is responsible for monitoring the use
6. The instructions, forms, and timelines required for completing and submitting an incident report by the person or persons who implemented the manual restraint **and**
7. The procedures and timelines for conducting the internal review and the expanded support team review, and the person or position responsible for completing the reviews and for ensuring that corrective action is taken or the person's coordinated service and support plan addendum is revised, when determined necessary.

DHS Licensing Division has sample policies on EUMR (PDF): www.dhs.state.mn.us/main/groups/licensing/documents/pub/dhs16_177363.pdf

In addition to meeting the conditions for EUMR and having a policy on EUMR, when EUMR is used it must be monitored and reported to the person, their team, DHS and the Office of the Ombudsman for Mental Health and Developmental Disabilities (OMHDD). The OMHDD and DHS have combined their reporting forms into the Behavior Intervention Report Form, described below.

Please note: multiple uses of a EUMR may trigger the requirement to develop a Positive Support Transition Plan. The PSR requires that a PSTP be developed when EUMR is used three or more times in 90 days or 4 or more times in 180 days.

> **PROVIDER REQUIREMENT:**
> A Positive Support Transition Plan is required when an EUMR is used 3 times in 90 days or 4 times in 180 days

Permitted procedures

Because there are some techniques and interventions that may not easily appear to constitute one of the prohibited or restricted procedures, the PSR notes a number of permitted actions and procedures. The following actions and procedures are permitted when used on an intermittent or continuous basis but, if used on a continuous basis, they must be addressed in the person's plan.

A. Physical contact or instructional techniques must use the least restrictive alternative possible to meet the needs of the person and may be used:
   (1) To calm or comfort a person by holding that person with no resistance from that person;
   (2) To protect a person known to be at risk of injury due to frequent falls as a result of a medical condition;
   (3) To facilitate the person's completion of a task or response when the person does not resist or the person's resistance is minimal in intensity and duration;
   (4) To block or redirect a person's limbs or body without holding the person or limiting the person's movement to interrupt the person's behavior that may result in injury to self or others with less than 60 seconds of physical contact by staff; or
   (5) To redirect a person's behavior when the behavior does not pose a serious threat to the person or others and the behavior is effectively redirected with less than 60 seconds of physical contact by staff.

B. Restraint may be used as an intervention procedure to:
   (1) Allow a licensed health care professional to safely conduct a medical examination or to provide medical treatment ordered by a licensed health care professional;
   (2) Assist in the safe evacuation or redirection of a person in the event of an emergency and the person is at imminent risk of harm; or
   (3) Position a person with physical disabilities in a manner specified in the person's coordinated service and support plan addendum.

   Note: Any use of manual restraint as allowed in this paragraph must comply with the restrictions identified in 245D.06, subdivision 6, paragraph (b).

C. Use of adaptive aids or equipment, orthotic devices, or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition do not in and of themselves constitute the use of mechanical restraint;

D. positive verbal correction that is specifically focused on the behavior being addressed; and

E. temporary withholding or removal of objects being used to hurt self or others.

Reporting Behavior Interventions: The Behavior Intervention Report Form

The Department has committed to monitor the use of behavior interventions used by the providers it licenses. It does this to ensure the protection of the health, safety and dignity of the people receiving services and to monitor the implementation of the PSR.

The following interventions/responses are behavior interventions that must be reported to the Commissioner on the Behavior Intervention Report Form (BIRF):

A. An emergency use of manual restraint;

B. A medical emergency occurring as a result of the use of a restrictive intervention with a person that leads to a call to 911 or seeking physician treatment or hospitalization for a person;

C. A behavioral incident that results in a call to 911;
D. A mental health crisis occurring as a result of the use of a restrictive intervention that leads to a call to 911 or a provider of mental health crisis services as defined in Minnesota Statutes, section 245.462, subdivision 14c;
E. An incident that requires a call to mental health mobile crisis intervention services;
F. A person's use of crisis respite services due to use of a restrictive intervention;
G. Use of pro re nata (PRN) medication to intervene in a behavioral situation. This does not include the use of a psychotropic medication prescribed to treat a medical symptom or a symptom of a mental illness or to treat a child with severe emotional disturbance;
H. An incident that the person's positive support transition plan requires the program to report; or
I. Use of a restrictive intervention as part of a positive support transition plan as required in the plan.

License holders must complete and submit the form within 15 working days of the intervention. Some programs may have other reporting timelines for different incidents. Please note the difference if this pertains to you.

The Behavior Intervention Reporting Form is required by the PSR. Timelines to submit the form are as follows:

- Within 3 calendar days after the use of a procedure, the staff person who implemented the procedure will report in writing to the designated coordinator in accordance with 245D.061, subd 5
- Within 5 working days of the emergency use of manual restraint, license holders must complete an internal review of the procedure in accordance with 245D.061, subd 6
- Within 5 working days after the completion of the internal review, the license holder must consult with the expanded support team in accordance with 245D.061, subd 7
- Within 5 working days after the expanded support team review, all external reporting must be completed in accordance with 245D.061, subd 8.

License holders must determine who or how many people in each licensed site or program they want to submit forms to DHS. Refer to the instructions document for more information when completing the form:

- Behavior Intervention Reporting Form (DHS-5148) https://edocs.dhs.state.mn.us/lfserver/Secure/DHS-5148-ENG
- Instructions and Definitions for the Behavior Intervention Report Form (PDF) http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs16_177490.pdf

DHS and the Office of the Ombudsman for Mental Health and Developmental Disabilities will not accept any versions of other forms for incidents occurring on or after July 1, 2013, from any providers required to use the new form. Please discard any versions of any other documents used to report these incidents.

Functional Behavior Assessments

"Functional Behavior Assessment" is often confused or used interchangeably with the terms "Functional Assessment" and/or "Functional Analysis". In Minnesota, the term "Functional Assessment" refers to an assessment under the Mental Health Act, performed by mental health case managers, professionals and/or practitioners to assess the impact of a person's mental health symptoms on their functioning.

The PSR uses the term Functional Behavior Assessment, or FBA, to refer to the assessment of interfering behaviors that:

1. Operationally defines the interfering behavior targeted for elimination or reduction. At this point, the interfering behavior becomes a "target behavior";
2. Identifies the situations in which the target behaviors are likely to occur and not occur; and
3. Generates a testable hypothesis of why the behavior occurs.

In general, there are three strategies used for collecting information in an FBA (O'Neill, Albin, Storey & Horner, 2015).They are:

1. Indirect assessment of the person and behavior - This can include interviews, surveys or questionnaires completed by the person or people familiar with the person.
2. Direct Observation of the person, the behavior and the situations in which the behavior occurs - This entails observing the person in their normal environment. This type of assessment typically notes the precursors or antecedents to the behavior, defines the behavior and then notes the consequences of the behavior. A commonly used direct observation method uses C-A-B-C recording (Context -Antecedent-Behavior-Consequence).
3. Functional Analysis - A functional analysis goes beyond direct observation by altering antecedents and consequences to see how the person behaves and whether it fits with the behavioral hypothesis. Functional analyses involve creating conditions to determine what variables contribute to the interfering behavior. Functional analyses are complicated and should only be performed by a person trained to do so.

An FBA is done almost any time a team tries to determine the cause/purpose/function of a behavior. Most FBAs do not require a lot of time or investigation. However, when a PSTP is required, a qualified professional must conduct an FBA (see Appendix J for the person who qualifies under your license) and evaluate all of the following elements and directly observing at least one:

FUNCTIONAL BEHAVIOR ASSESSMENTS AT-A-GLANCE

- Performed anytime a team is trying to determine the purpose or function of a behavior

- Required during the PSTP development or anytime a target behavior or intervention is modified in a PSTP

- Must be performed by a Qualified Professional. See Appendix J for a listing of who qualifies in each licensed setting

A. Biological factors, identified through a medical assessment or a dental assessment;
B. Psychological factors, identified through a diagnostic or suicidality assessment;
C. Environmental factors, identified through direct observation or interviewing a significant individual in the person's life; and
D. Quality of life indicators based on the person's goals and needs within the domains of a meaningful life.

Beyond the creation of a PSTP, an FBA is required any time a qualified professional develops or modifies a written intervention to change a target behavior. Specifically, if changes are made to the target behavior or target intervention section of a PSTP (described below), a new FBA is required. Note the results of the FBA on the PSTP and revised PSTP.

See Appendix L and Appendix M for sample assessments that may be included during an FBA process.

The hypothesis created during the FBA process will be noted in the Positive Support Transition Plan (described further in the next section). These hypothesis should outline what typically precedes a behavior (setting events), what triggers interfering behavior, what the interfering behavior is and what consequences appear to maintain the interfering behavior.

Function-based interventions

After creating a hypothesis of what purpose or function the target behavior serves, the next step is to create a function-based intervention. The goal of a function-based intervention is to make the target behavior irrelevant, ineffective and efficient for a person. These interventions are based on the strong hypothesis about why problems are occurring.

Once we have ruled out biological issues, there are basically three accepted functions a typical target behavior may serve:

1. To obtain positive reinforcement.
   a. This includes things like gaining attention or access to something (an activity, item, etc.). This could even include gaining social status or approval (Daffern et al., 2007)
2. To avoid or escape something.
   a. This includes escaping an unwanted situation or avoiding something (or someone) undesirable
3. To receive automatic reinforcement. This comes in two forms:
   a. Sensory stimulation – doing something because it feels good or
   b. Pain reduction – doing something to relieve pain, pressure or stress

For more information on choosing a function-based intervention, please visit www.mnpsp.org

The following websites may also be of use for information on FBAs:

A. Kansas Institute for Positive Behavior Support
   a. http://kipbs.org/new_kipbs/fsi/behavassess.html
      i. Contains tools for direct & indirect assessment, vignettes/tools/examples for data collection, suggested readings, and much more
B. Practical Functional Assessment
   a. http://practicalfunctionalassessment.com/
C. Functional Assessment Screening Tool (PDF)
   a. http://adapt-fl.com/files/FAST.pdf

D. Functional Behavior Assessment Observation Form (.DOC)
   a. http://www.pbisnetwork.org/wp-content/uploads/2011/10/Functobserv1.doc
E. Questions About Behavioral Function
   a. http://www.disabilityconsultants.org/QABF.php
F. Motivation Assessment Scale
   a. http://www.monacoassociates.com/#!products/c1rzz
G. Functional Assessment Checklist for Teachers and Staff (FACTS) (PDF)
   a. http://www.pbis.org/common/cms/files/pbisresources/EfficientFBA_FACTS.pdf

The Positive Support Transition Plan (PSTP)

Minnesota Statute, section 245D.06, subdivision 5 and Minnesota Rule, section 9544.0060 subpart 1 prohibits the following procedures as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience:

1. Chemical restraint
2. Mechanical restraint
3. Manual restraint, except in an emergency
4. Time out
5. Seclusion
6. Aversive procedures
7. Deprivation procedures

These prohibitions took effect on January 1, 2014 for 245D-license holders and on August 31, 2015 for all other providers governed by the PSR. Under previous regulations, teams may have used one or more of the prohibited procedures. License holders may continue to use certain prohibited procedures during a one-year phase out process if they are included in a [Positive Support Transition Plan (PSTP) (DHS-6810)](#) and adhere to the [Commissioner's instructions (DHS-6810B)](#).

The development of a Positive Support Transition Plan is required to:

• Eliminate the use of prohibited procedures identified in Minnesota Statutes, chapter 245D
• Avoid the emergency use of manual restraint
• Prevent the person from physically harming self or others

A Positive Support Transition Plan directs the actions of a service provider; it outlines the support and procedures providers will use with the persons they serve. A PSTP is required in response to multiple uses of a EUMR; 3 or more uses in 90 days or 4 or more uses in 180 days. A PSTP is also required when a person and their team identify a need for the therapeutic fading of a prohibited procedure. In other words, if a team believes immediately stopping a previously used procedure would cause harm to the person or others, they may continue to use the procedure for a limited time in conjunction with a PSTP.

License holders who do not use a prohibited procedure or the emergency use of manual restraint do not need to create a PSTP. Expanded support teams are encouraged to fade the use of the prohibited procedure as soon as possible, but no more than 11 months after the creation of the PSTP. For PSTPs developed due to the frequent implementation of EUMRs, the external support team must determine timelines for the fading of the PSTP.

Goals of a PSTP

The reduction of dangerous behavior is a necessary, but not a sufficient goal of the PSTP. The PSTP must also aim to reduce prohibited interventions and the emergency use of manual restraint, as well as positively affect the lifestyle of the individual so that his or her quality of life is enhanced. These are the four primary goals of a PSTP:

1. Decrease target behaviors that jeopardize the safety of the person or others;
2. Fade and eventually cease the use of prohibited interventions (target interventions);
3. Decrease the emergency use of manual restraint as defined in 245D;
4. Increase the quality of life of the person served.

It will be up to those people who provide direct services to implement the plan, record any relevant data, and provide feedback, in conjunction with the person served, as to the plan's effectiveness.

The foundation of a PSTP is provided primarily by a person-centered plan and secondly by a functional behavior assessment (FBA). The PSR requires that a qualified professional conduct the FBA. It is the FBA that operationally defines the target behaviors to be eliminated, identifies the situations which the behaviors are likely to occur and not occur, and generates a hypothesis of why the behavior occurs. As noted in What Influences Behavior, behavior can stem from a number of factors: physiological; social; psychological; and environmental. The FBA will attempt to determine the specific factors contributing to the target behavior(s).

In the development of the positive support transition plan, these considerations are essential:

1. We do not change people. In the implementation of a PSTP, our focus is less on the target behaviors than the context in which these behaviors occur (Carr et al., 2002) and positive behaviors. Attempts to change the persons who display dangerous behaviors often result in the application of an emergency safety intervention. The very nature of the PSTP is to end punitive practices and avoid attempts to force behavioral change by using intrusive measures. By identifying and modifying contextual elements in the environment to promote desired behavior, and building a repertoire of positive behavior, dangerous behaviors become irrelevant, ineffective, and inefficient in generating outcomes that work for the person

2. Change in care provider attitudes and behavior is essential. PSTPs are tailored for the benefit of the person we serve, by providing a guide for how care providers' behavior can build positive behaviors and limit the frequency, duration, and intensity of dangerous behaviors (Lucyshyn, Kayser, Irvin, & Blumberg, 2002). That is, we do not force changes in the persons; rather, our behavior as service providers changes so that outcomes valued by the person can be obtained without dangerous behaviors. PSTPs are written for those implementing the support procedures. A clear description of the procedures, expectations, and provider responsibilities is essential for successful implementation.

3. The values inherent in a PSTP are essentially three-fold. O'Neill et al. (p. 8) list the following:
   a. Behavioral support must be conducted with the dignity of the person as a primary concern. This value acknowledges that target behaviors are functional for the person. That is, the target behaviors are not a result of a disability or medical condition; these behaviors serve a purpose
   b. The understanding of the function and structure of interfering behaviors is necessary in order to teach and promote effective alternatives. It is important that we identify: (1) situations where the interfering behaviors are apt to occur and ways to modify contexts so these behaviors are less likely; (2) functionally equivalent, alternative skills that are more effective and efficient than the interfering behaviors; (3) care providers' responses to the interfering behaviors.
   c. We obtain information from the functional behavior assessment that examines the relationship between the interfering behaviors and the environment. The PSTP incorporates information about the behavior, the structural features of the environment, and the patterns of support including the behavior of the care providers.

It is important that the person not be "blamed" for the behavior he or she exhibits. For the person, interfering behaviors are effective, efficient, and relevant in the attempt to obtain goals or escape from undesirable situations in which they don't feel in control.

4. Goals of a PSTP. The goals of a PSTP are primarily threefold:
   a. First, person-centered values promoting the person's goals, desires, and preferences are honored. Person-centered futures planning (Kincaid, 1996), lifestyle planning (e.g., Smull, 2002), and self-determination (Wehymeyer & Hughes, 1998) are important elements of person-centered values.
   b. Second, community integration in the mainstream of society that provides employment and recreational activities that correspond with the person's preferences is important. The reduction of interfering behaviors is a necessary, but not sufficient goal of the behavior support plan. The PSTP must also positively affect the lifestyle of the person to enhance his or her quality of life.
   c. Lastly, it is important for intervention to decrease the frequency of the target behavior, especially if it jeopardizes the safety of the person or others. These behaviors often deny the persons enriching community-based opportunities.

Crisis Planning

The prohibition of the target interventions described above requires providers to engage in crisis planning for the

persons they serve. The Minnesota Department of Human Services(DHS) uses a crisis framework comprised of five stages as depicted in the diagram below:
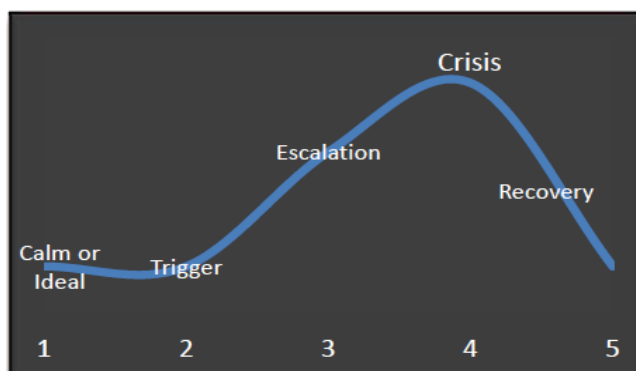
DHS uses this framework to promote a common understanding and reporting of crises. For the purposes of the Positive Supports Transition Plan (PSTP), "crisis" refers to a situation that exceeds a person's resources and coping mechanisms and has the potential to endanger their health and safety of or the health and safety of others. The framework can also help teams look at ways of reducing recurring crises. This section should detail the strategies used to fade out/eliminate the use of the restrictive procedure(s).

Calm or ideal stage

The **calm or ideal stage** indicates what typical or calm functioning would look like for a person. "Calm or ideal" varies for every person and/or event. Teams identify the person's optimal state and past support strategies to help the person maintain this state. This stage is best addressed by teaching the person alternative/replacement behaviors and skills that are incompatible with the targeted behaviors.

Trigger stage

The **trigger stage** indicates situations, words, people, decisions, critical periods, biological event or condition, etc. that can set a person towards a crisis. Triggers are antecedent events that lead to a behavior. An antecedent immediately before a behavior (such as a loud noise or a criticism) is referred to as a "fast" trigger. An antecedent that began at an earlier time (such as fatigue or hunger) is called a "setting event" or a "slow" trigger. Setting events increase the likelihood of a non-desired behavior but do not necessarily spark one. At this stage it is important to look at what adaptive, socially appropriate alternative behaviors can be taught to replace the

occurrence of the targeted behaviors. Are there setting events that can be addressed to avoid the occurrence of the targeted behaviors? What contextual changes can occur within the environment that support socially appropriate behaviors.

The idea behind crisis prevention is that a team assists a person to either avoid or cope with triggers. The person and their team must decide which method of crisis prevention is best suited to each trigger. Teams identify proactive and reactive ways to support a person when encountering triggers and ways to avoid or minimize the intensity of the trigger. Proactive strategies focus on strategies to use before a known trigger/antecedent will be encountered. Reactive strategies focus on strategies to use after encountering a trigger/antecedent.

Table 3: Common "fast" triggers

Social	Environmental
Major life changes	Air quality
Loss of family member	Proximity to others
Being Stared at	Time of day
Change in staff	Lighting
Criticism	Noise
Disapproval	Smells
Not having choices	Temperature
Relocation	Surfaces
Teasing by others	Transitions
Tone of voice	

Table 4: Comment setting events – "slow" triggers

Psychological	Physiological
Anxiety	Allergies
Boredom	Cravings
Depression	Earaches
Fear	Headaches
Phobias	Hunger/Thirst
Paranoia	Infections
Sexuality Issues	Itching
Transitions	Pain
	Fatigue

See Appendix M for a sample Settings Event Checklist that can help you identify setting events with the people and in the situations you are working with.

De-escalation is the planned way of limiting the impact of a crisis. On a long-term basis, people who may have crisis events should have support plans (including de-escalation procedures) that include environmental accommodations, therapies, health care and medications, opportunities to develop strong relationships, work and volunteer opportunities, education, and/or community involvement that could, in part, alleviate symptoms and to avoid crises. A good support plan addresses how to manage both slow triggers and fast triggers so their impact on the person is negated or minimized. Included in Appendix C is a link to the University of Kansas' website, which provides resources for intervening in different setting events.

Escalation stage

The **escalation stage** refers to the behaviors or symptoms that typically emerge after a trigger and before a crisis. This is a critical period in which there is an opportunity to assist a person to avoid a crisis.

Because crises often endanger someone's health and safety, an intervention is typically necessary. When a crisis stage poses a risk of injury to someone and all other intervention methods have failed, the crisis becomes an emergency safety situation. According to Minn. Stat §245D.061, the crisis stage is the only time when emergency use of manual restraint is allowable. For license holders who do not use emergency use of manual restraint, another intervention strategy must be identified, such as calling a crisis line or 911.

Recovery stage

The **recovery stage** refers to the period just after a crisis as people or events are on their way back to the calm or ideal phase. The goal of the recovery stage is to assist a person in returning to the calm or ideal stage and the stream or flow of normal life activity. Strategies for support may include debriefing with the person, suggesting the person call a friend, or giving the person space.

Listening is a critical component of person-centered planning and avoiding or intervening in a crisis. What follows in Table 1 are some good tips to use when communicating with people you are supporting.

Table 5: Personal Conduct that says you are listening and can minimize negative responses
Adapted from Guidelines for Supporting Adults with Challenging Behaviors in Community Settings (PDF)

Following these suggestions in your daily interactions with others will assist you in minimizing and de-escalating negative responses from others. If at any time another person's behavior starts to escalate beyond your own comfort zone, discontinue the situation.

DO this	DO NOT do this
Focus your full attention on the other person to let them know you are listening and interested in what they are saying.	Engage in other activities or tasks while the other person is speaking.
Encourage the other person to talk. Listen patiently and with empathy.	Argue or reject the other person's values, dreams, or point of view.
Maintain a pleasant, open and accepting attitude.	Know the person before you use humor… Jokes can be misinterpreted as making fun of someone.
Stay calm. Move and speak slowly, quietly and project confidence. Watch your own body language, voice pattern, facial expressions and rate of speech.	Do not use a style of communication that suggests apathy, "the brush-off", coldness, sarcasm, condescension, minimizing concerns, or giving the run-around.
Maintain a relaxed posture, positioning yourself at a right angle.	Don't stand directly face-to-face, hands on hips, crossing arms, finger pointing, or hard stare eye contact. These are very challenging behavioral messages.

DO this	DO NOT do this
Make sure there are 3 to 6 feet between you and person with whom you are speaking.	Don't invade another person's personal space. Don't lean into or over the person.
	Don't touch the person if the person is not harming himself or herself or someone else. Touching escalates behaviors in the moment.
Make sure you are at a level of eye contact with the person. Adjust your position so that you are communicating with the person literally at the level of their physical height so that their eyes can look at your eyes without difficulty.	Don't tower over a short person or a person in a bed, chair or wheelchair.
Be brief, direct and to the point.	Don't speak with a lot of technical terms, use large vocabulary words, or use long phrases especially when emotions are high.
Listen actively and objectively.	Don't take sides with what the person is saying. Don't agree with distortions. Summarize and use clarification to make sure the full story is communicated
Acknowledge the other person's feeling even if you disagree. Let them know that it is clear that what they are saying is important.	Don't challenge, threaten or dare the other person. Never belittle or make fun.
When acknowledging a person's feelings, use words like "frustrated," "upset" or other words that describe a softer version of the emotion displayed. When addressing a negative feeling ask what about the situation makes them feel that way and ask about the feelings that go with those situations.	Don't use words that are emotionally charged, like "angry" or "pissed off." These words can prolong agitation or increase escalation. If the emotion that you named is NOT on target, allow the person the control of naming the emotion!
	Don't try to make it all seem less serious than it is. Do NOT minimize the person's feelings!
Even if you disagree, you can still listen to someone. You might say something like "I hear what you are saying, but I don't share that same view…"or "I hear what you are saying… but have you considered XXX?" Roll with resistance and offer options by saying something like "it is frustrating but is there something else we can do or try?"	Don't argue back to or over the person. Don't try to change their mind about something.

DO this	DO NOT do this
Accept criticism in a positive way. If a complaint is valid, use statement like "you are probably right". If the criticism is invalid, ask clarifying questions.	Don't criticize or act impatiently toward an agitated person.
Break big problems into smaller, more manageable problems.	Don't focus on a person's inabilities to manage problems
Ask for small, specific responses from them such as moving to a quieter area or lowering their voice. Focus on small requests.	Don't ask for a series of tasks to do in the same time
Be reassuring and point out the choices available to the person. Allow them to have control of the choice made to the extent possible given the circumstance.	Don't present a controlling attitude and a forceful voice
Be genuine and speak truthfully.	Do not make false statements or promises you know you cannot keep. If you are unsure, say that you are unsure.
Establish ground rules or set boundaries if unreasonable behavior continues. Calmly describe the consequences of any inappropriate behavior.	Do not attempt to bargain or bribe a threatening person.
Ask for their opinions or recommendations. Paraphrase back to the person what they said.	Do not immediately reject demands made without listening and communicating to the person that you are hearing the words and/or the message that is not directly in the words.
Use delaying tactics that will give the person time to calm down. For example, offer a drink of water in a paper cup.	Don't push the person to the point of irritating or escalating in undesirable behavior
Position yourself to have access to an exit if need be. Be aware of surroundings and people walking in and out, but try to maintain a soft eye contact.	Don't exhibit a high anxiety level around the person

The Emergency Use of Manual Restraint (EUMR)

Even in cases when a PSTP is in place, Minn. Stat. §245D.061 does allow for the "emergency use of manual restraint" as a safety management tool. However, this use must meet both of the following conditions:

1. Immediate intervention must be needed to protect the person or others from imminent risk of physical harm. (Property damage, verbal aggression, or a refusal [to receive or participate in treatment or programming] do not constitute an emergency.)
2. The type of manual restraint used must be the least restrictive intervention to eliminate the imminent risk of harm and effectively achieve safety. The manual restraint must end when the threat of harm ends.

Manual restraint is not a clinical tool and providers will determine if they will allow EUMR as a safety management tool. Providers must develop an *Emergency Use of Manual Restraint (EUMR) policy* to inform staff and people receiving services of what action they will take in an emergency – even if they do not allow the use of EUMR.

If a provider does not allow for the emergency use of manual restraint, they must determine what measures will be taken to protect the health and safety of the persons they serve during a crisis. These alternate measures must be identified and documented in the provider's EUMR policies and procedures.

Sample statements that providers can customize are available on the DHS Website:

- Sample Policies and Forms for Basic Supports and Services (PDF)
  http://www.dhs.state.mn.us/main/groups/licensing/documents/pub/dhs16_177363.pdf
- Sample Policies and Forms for Intensive Supports and Services (PDF)
  http://www.dhs.state.mn.us/main/groups/licensing/documents/pub/dhs16_180212.pdf

Note: In addition to the sample documents related to the emergency use of manual restraint, these web pages have other samples of related forms that 245D licensed providers may link to and modify for use in their programs.

Monitoring Quality of Life

As noted many times in this manual, the goal of positive support strategies is to increase a person's quality of life. As we move towards a culture that seeks to enhance the quality of life of all persons receiving services, changes are continuously necessary to the way we plan, provide and judge the services. In the past, while the goal of disability services was to increase a person's autonomy, the emphasis of many services was to decrease instances of targeted behaviors. If targeted behaviors decreased, it was determined that the treatment was effective. If targeted behaviors increased, a new treatment or strategy was necessary. This old model is insufficient because it often did not take into account the person's quality of life.

Under the old model, to stop a person from physically aggressing towards another, for instance, the person could have been forced to sit in a chair with their hands strapped to the arms. This would have been deemed effective treatment if their targeted behavior, physical aggression, decreased. However, what happened to that person's quality of life? Unless the person really enjoyed being strapped to a chair, their quality of life was certainly diminished.

The person and their team will ultimately decide the effectiveness of any treatment. To aid this process, providers are asked to track the effectiveness of treatment through daily interaction and training with the person and data collection. Providers will be asked, regardless of whether the person is taking psychotropic medications or receiving behavioral training, to track the target symptoms and quality of life of the people they serve. Remember, quality of life is determined by identifying what is important to the person during the person-centered planning process.

Evidence shows when quality of life increases, interfering behaviors decrease. Sometimes, however, unwanted side effects occur. Sometimes new interfering behaviors develop, so while one target behavior decreases, another one surfaces or increases. Sometimes target behaviors will go down, but because a person's freedoms are restricted, their quality of life can also decrease.

While all teams should monitor the quality of life of the people they serve, in the last section of the PSTP, teams must determine which quality of life indicators, quality indicators, to monitor during the transition from restrictive interventions to positive supports. Quality indicators are reportable or observable outcomes that are important to or important for the person. To the extent possible, quality indicators should be chosen that reflect things the person's target behaviors prevent them from accessing/achieving. Because quality of life is impacted by many factors, teams must choose a minimum of two quality indicators to monitor, one from two different domains listed below:

1) **C**ommunity Membership
2) **H**ealth, wellness and safety
3) **O**wn place to live
4) **I**mportant Long-term relationships
5) **C**ontrol over supports, and
6) **E**mployment earnings and stable income

The PSTP form provides these categories in a drop-down menu in Part E. Remember, these are just domains, not the indicators themselves. These domains must be used in the PSTP, but can also be used during the evaluation of person-centered plans to show if quality of life is improving. Improving quality of life naturally decreases the likelihood that interfering behaviors will occur. Table 4 provides some quality indicators for each of the domains:

Table 6: Quality of Life Domains and Quality Indicators to Measure Each Domain
Adapted from Schalock, R., & Verdugo, M.A. (2002). Handbook on quality of life for human service practitioners. In D.L. Braddock (Ed.). Washington, DC: American Association on Mental Retardation.

Domain	Common Quality Indicator
Community Membership	• Community integration/participation levels • Roles in community that bring respect and social equity • Community involvement and social supports
Health, wellness and safety	• Status of health • Activities that include exercise, stimulation and relaxation • Leisure – quality and number
Own place to live	• Control over person's living arrangement • Person is living where they would like to/in the most integrated setting
Important Long-term relationships	• Interactions with others – frequency and/or quality
Control over supports	• Extent to which person can control important life experiences • Choice making opportunities • Extent goals and personal values are acknowledged
Employment earnings and stable income	• Employment – Type and Preference • Person's income increases

Domain	Common Quality Indicator
	• Person has control over income and how money is spent

Positive Support Transition Plan Reviews and Judging the Effectiveness of the PSTP

During the review of a Positive Support Transition Plan, which must occur at least quarterly, the team must evaluate data from the previous reporting period. The team reviews the incidence of target interventions, target behaviors and quality of life. Based on the review of the data, the team determines whether or not to continue with the PSTP as-is, revise the PSTP or to terminate the plan. Table 5 provides possible outcomes to aid teams in their determination. Table 5 does not include outcomes for target interventions, as it is already required that these interventions decrease. If the team does agree to revise the PSTP, the new plan must be in place within seven working days of the review.

Complete Positive Support Transition Plan Review DHS-6180A at each formal review. Reviews must occur no less frequent than every quarter. A completed form DHS-6810A must be placed in a person's service recipient record. A copy of the completed form must also be sent to DHS at positivesupports@state.mn.us

Table 7: Judging the effectiveness of treatment

Target Behavior	Quality of Life	Effective Treatment?
Decrease	Decrease	No
Decrease	Stable	Possibly
Decrease	Increase	Yes (optimum)
Stable	Decrease	No
Stable	Stable	No
Stable	Increase	Possibly
Increase	Decrease	No
Increase	Stable	No
Increase	Increase	No

Looking at the chart, one can see there are nine possible treatment outcomes but only one outcome considered an effective treatment. It is possible that some of the other outcomes may seem acceptable, but while any decrease in a target symptom can be considered effective symptom management, only when a decrease in target symptom is accompanied by an increase in quality of life can we consider a treatment program effective.

Seeking assistance

Teams must request assistance if a PSTP has been in place for six months and there is not a decrease in the incidence of target interventions. Assistance can be requested through an external service provider when facilitated by the case manager.

Other plans to use when a Positive Support Transition Plan is not required

Adapted from [Guidelines for Supporting Adults with Challenging Behaviors in Community Settings (PDF)](#)

Even though a PSTP may not be required, a person and their team may decide that due to some circumstance or situation, some sort of plan would be useful. The PSR does not require a plan in any other circumstance than as noted on . Even so, a team may decide the format of the PSTP would best suit the situation. Teams may use the PSTP even when not required to plan for the reduction of an intervention, a target behavior and/or increase the person's quality of life.

The PSTP format was developed with input from many stakeholders and incorporated parts of many other existing plans, such as Wellness Action Recovery Plans, Crisis Support Plans and Positive Behavior Support Plans. A team may find that one of these plans could best fit a current situation. A description of those plans is found below.

Wellness Recovery Action Plans (WRAP)

The Wellness Recovery Action Program is a structured system for monitoring uncomfortable and distressing symptoms and, through planned responses, reducing, modifying or eliminating those symptoms. It is usually peer led and includes plans for responses from others when a person's symptoms have made it impossible for the person to continue to make decisions, take care of him or herself and keep him or her safe. When WRAP is used, the person is able to MINIMIZE or AVOID interfering behaviors that can result when symptoms are not properly addressed. Illness Management and Recovery (IMR) is a similar recovery plan developed for use on the provider side to help support health and wellness through greater understanding and management of symptoms and triggers to mental illness

While this approach is being taught and used in mental health care, persons in DD care who have the cognitive and verbal or expressive skills to describe how they feel and what helps them feel better or worse could also use it.

Anecdotal reporting from persons who are using this system indicates that by helping them feel prepared, they feel more in control of their lives resulting in a better quality of life, even when symptoms of the illness are troublesome.

What follows is the basic outline of a WRAP Plan.

Basic outline of a WRAP Plan

Section 1: Daily Maintenance Plan

> Part 1: Description of how you feel when you feel well
> Part 2: List everything you need to do every day to maintain wellness

Section 2: Triggers

> Part 1: Events or situations that might cause symptoms to begin
> Part 2: A plan of what to do if the triggers occur

Section 3: Early Warning Signs

> Part 1: Identification of subtle signs that indicate a worsening situation
> Part 2: A plan of what to do if these early warning signs occur

Section 4: Symptoms That Indicate Worsening

> Part 1: What to do if these symptoms occur

Section 5: The Crisis Plan

> Part 1: What I am like when I am feeling well
> Part 2: Symptoms that say I am not doing well
> Part 3: Who are my supporters?
> Part 4: Medication that works; medication that does not work
> Part 5: Treatments that work; treatments that do not work
> Part 6: Where can I go in the community?
> Home/Community Care/Respite Center
> Part 7: Treatment facilities that are options for me
> Part 8: What help do I need from my supporters?
> Part 9: How do my supporters know I am better?

Section 6: Post Crisis Planning

> Descriptive behaviors, feelings and activities that will indicate healing is under way.

Crisis Plans

Crisis plans are used largely in the mental health side of care. However, any person who has the cognitive and verbal or expressive skills to describe how they feel and what helps them feel better or worse can develop a crisis plan. This can be accomplished independently or with the help and support of a professional.

Crisis plans are part of the Wellness Recovery Action Plan[3] (WRAP Plan) that is developed by the person. A professional may give guidance to assure the plan is well thought through, but the crisis plan should represent the person's work and their wishes.

Noticing and responding to symptoms BEFORE they manifest as interfering behaviors reduces the chances that the person will be in crisis. By writing a clear crisis plan when the person is well, he or she can instruct others about care when he or she is not well. Thus, the person maintains responsibility for his or her own care.

The crisis plan portion of the WRAP Plan is different from the rest of the WRAP Plan in that other persons will use the crisis plan on behalf of the person. Once the person has completed their personal crisis plan, copies of the plan should be given to the people identified in the plan as supporters.

The essential components of a crisis plan are listed below, written from their perspective in the first person:

1. Describe what I'm like when I'm feeling well
2. List the symptoms the would indicate to others that they need to take over responsibility for my care and make decisions on my behalf
3. Identify my supporters or those people who I want to take over for me when the symptoms come up
   a. There should be at least five people on the list of supporters
4. List all of the information about my medications
   a. The name of my physician or physicians and phone numbers

      b.   My pharmacy and the number

      c.   My allergies

      d.   The medications I am currently on

          i.   Why I take these medications

      e.   The medications I prefer to take if medication becomes necessary

          i.   Additional medication I prefer to take if required

          ii.   Why I choose these medications

      f.   The medications that should be avoided

          i.   Why those medications should be avoided

5. List the treatments I would want in a crisis situation

      a.   Tell why the treatment is selected

      b.   Also list treatments that have negative connotations

          i.   Why those treatments feel bad or don't work

6. Identify options for community care

      a.   Would you be able to stay at home?

          i.   If so, what supports would you need to make that happen

      b.   Is community care outside of the home an option as an alternative to hospitalization?

          i.   If so, identify what that is, where it is and how to access it

      c.   Is respite an option?

7. Specify where you would go if you need a safe facility outside the scope of community care

      a.   Where do you want to go?

      b.   Where do you want to avoid?

8. What do I need my supporters to do for me?

      a.   What could they do that would reduce symptoms?

      b.   What could they do that would help me relax?

      c.   What could they say to me that helps?

      d.   What could they do for me that MUST be done?

          i.   Get the mail

          ii.   Feed the pets

          iii.   Pick up the kids

          iv.   Pay my bills

      e.   What do my supporters need to avoid because those things make me worse?

9. How do my supporters know when to back off or that I am feeling better?

The crisis plan should be updated whenever there is new information that needs to be shared or when a different decision is made that needs to be communicated. Remember that the supporters need to have copies when this information is updated.

Positive Behavior Support Plans

A positive behavior support plan (PBSP) is a formal plan to help everyone do the same thing on a consistent basis. The plan is based on an assessment of the interfering behavior that includes person centered practices such as understanding the strengths, preferences and interests of the person, the context in which the interfering behavior occurs, the desired goal that is to be achieved, and the A-B-C's related to the behavior that is of concern.

The plan consists of using the fewest interventions or support strategies possible coupled with reinforcement for appropriate alternative behaviors that will modify, decrease, re-direct or eliminate the interfering behavior. Success is measured by reductions in interfering behaviors, performance of alternative skills, and improvements in quality of life.

The plan uses ONLY positive interventions to replace the interfering behavior with other behavior judged more acceptable. The PBSP does not use any restrictive or unpleasant techniques to modify interfering behaviors.

The PBSP couples the science of behavior analysis with person-centered values that respect the person. These values include but are not limited to:

1. Understanding the person's "story," including their strengths, skills and limitations
2. Having respect for the person's desire to follow his or her dreams to live life as normally as possible while being supported to overcome the interfering behavior
3. Respect of his/her dignity, the right to make choices, and the right to live as independently as possible

The person with the interfering behavior must be made aware of the plan as evidenced by their signature or the signature of their representative or legal guardian.

Fourteen outcomes you should expect to find in a completed PBSP

The development of a PBSP includes a written plan for ALL involved persons to follow. The following fourteen outcomes are critical in achieving a consistently positive approach in all aspects of the person's life.

1. **Ensure that a person-centered approach is used to drive the development of the plan.** This may seem obvious, but plans can quickly become "controlling," in the name of safety when addressing severely interfering behaviors. A PBSP should always be informed by a thorough and competent person centered plan.
2. **Establish clear operational definitions of behaviors to be increased as well as those to be decreased.** This means using descriptive terms that everyone understands so that there is consistency in identifying the interfering behavior:
   a. There must be **agreement** between the professional and staff as to the behavior that is occurring.
      i. Behaviors must be described in **observable** terms
      ii. Behaviors must be described in **measurable** terms
3. **Ensure that the plan is practical… that it can be done.** A plan that is not practical, that is cumbersome, that does not consider practical, day-to-day issues WILL FAIL.
4. **Identify the contexts, antecedents and consequences that influence the occurrence of the behaviors of concern.** It is critical to a PBSP to know what events, both before and after a behavior, increase the likelihood of that behavior's occurrence.
5. **Ensure that functional skills are taught as part of the active treatment routine.** Learning efforts should focus on meaningful and purposeful skills that:
   a. Support the person's choices and goals;
   b. Are essential to personal independence;
   c. Are needed often;
   d. Afford opportunity to participate in meaningful, purposeful and age-appropriate activities;
   e. Enable the person to do and attain the things they desire as well as to avoid those things they dislike.

6. **Ensure the person's environment is a positive, healthy, educational, supportive, nurturing, safe and therapeutic environment that:**
   a. Encourages and honors choices by the person;
   b. Promotes normalcy;
   c. Is suited to the person's needs; and
   d. Includes the person's preferred items and events.

7. **Identify and reduce or eliminate conflicts regarding person choice making.** Ensure that choice is built into the plan and that everyone involved knows how to help the person express choices (especially if the person does not use words to talk).
   a. Not having choice means not having control;
   b. Not having control means anger;
   c. Anger will be expressed by interfering behaviors

8. **Ensure that positive and meaningful social interactions are available with both peers and staff.** Identify and reduce or eliminate social interactions that contribute to the occurrence of interfering behavior. Ensure that everyone involved knows how to interact with the person in a group setting, how to interact in a positive way, and how to interact in a manner that is suited to the person's capacity as well as chronological age.

9. **Ensure that everyone involved knows how to use prompts, error correction, and task analysis** to increase the likelihood of desirable appropriate behavior. These methods help increase consistency from setting to setting and from person to person.

10. **The plan should identify teaching methods such as "prompting", "shaping" and "backward and forward chaining."** These methods make teaching and learning easier by conducting learning activities in smaller segments at a pace suited to the person's abilities.
    a. If you ever taught someone to throw a ball, you used "shaping"
    b. If you ever taught someone to memorize his or her phone number, you used "chaining."

11. **Ensure that the fundamental components of the PBSP are clearly described and understood by everyone involved.** Regardless of the format used for a PBSP, the fundamental components should address the following:
    a. What are the behaviors to increase?
    b. What are the behaviors to decrease?
    c. What things should be provided in the person's environment on a day-to-day basis to decrease the likelihood of interfering behaviors?
    d. What things should be avoided in the person's environment on a day-to-day basis to decrease the likelihood of interfering behaviors?
    e. What event(s) are likely to occur right before a behavior of concern?
    f. What should you do if that event(s) happens, or what can you do to keep it from happening?
    g. What should you do if the behavior to increase occurs?
    h. What should you do if the behavior to decrease occurs? This **should not** involve punitive reprisals, unpleasant consequences or any other restrictive interventions.

12. **Ensure that staff knows when to ask for help! You have a right and responsibility to ask!** The professional should identify, with the help of staff, the types of problems that may occur when implementing a PBSP, and should be certain that everyone knows who to ask for help if implementation problems occur.

13. **Ensure that there is some form of reliable data collection taking place.** This should be simple, efficient and manageable for staff. The professional should establish the means for evaluating effectiveness of the PBSP using an efficient, reliable data collection and analysis method. This is essential to making sound decisions regarding continuation, revisions, or discontinuation of a PBSP.
14. **Clear criteria for determining whether the plan is succeeding or failing.** While the data described in #13 are critical, they must be connected with clearly stated criteria that tell us if the plan works or not.

What do I do if the PSTP isn't working?

Step 1: Seek additional review and consultation

The first answer is to re-evaluate the PSTP, as well as the implementation of the plan by direct support staff. As mentioned previously, an official review must occur at least every quarter. That said, direct support staff and those implementing the plan will have a good idea if the plan is working in a matter of days. Actions to take and issues to consider in the re-evaluation of any plan include but may not be limited to the following:

1. Call the professional who wrote the PSTP and ask for re-evaluation of the plan and implementation of the plan
2. Talk with the person to the extent possible regarding the plan and its implementation
3. Talk with the staff regarding the plan and its implementation
4. Assure that the plan has been implemented in a personal, caring and consistent manner
5. Affirm with staff what they are doing right
6. Update and adjust the plan as necessary
7. Invite the expanded support team to review and discuss the concerns
8. Invite subject experts to sit in, including DHS staff
9. Seek external consultation as required (see the section on PSTP Reviews for requirement)

REMEMBER: something that works initially will not be effective indefinitely. The plan will have to be tweaked and revised on more than one occasion. Consider the PSTP a living document in need of updating as needed.

Step 2: Seek assistance from DHS

1. When the above steps have not worked, a team may consider seeking assistance from DHS. Send your requests to positivesupports@state.mn.us.

What do I do if we are nearing the deadline to phase out a prohibited procedure, and the PSTP still isn't working?

If you have followed the above steps and the team does not believe a prohibited procedure can be phased out by the 11-month deadline due to a safety concern, there is one option available. The Commissioner has limited authority to grant approval for extending the use of procedures if the following conditions are met:

1. The procedures have been a part of a PSTP. The procedures must either:
   a. Protect a person at imminent risk of self-injury due to self-injurious behavior, or
   b. A procedure is not specifically permitted or prohibited by the PSR, and is necessary to protect the person's health and safety for a limited time while effective positive support strategies are developed and implemented
2. The person's expanded support team approves the emergency use of the procedures
3. An External Program Review Committee (EPRC) recommends that the Commissioner approve the procedures.

The EPRC has developed a request form for these requests: Request for the Authorization of the Emergency Use of Procedures form (DHS-6810D). Requests for the use of a prohibited procedure must also include the following information:

1. A copy of the person's current PSTP, copies of each PSTP review, if any, and data on the interfering behavior;
2. Documentation of methods the provider has tried to reduce and eliminate the incidence of interfering behavior that have not been successful;
3. Documentation of the assessments performed to determine the function of the behavior for which the interventions have been developed;
4. Documentation of a good faith effort to eliminate the use of restrictive interventions currently in use;
5. Documentation that the interfering behavior is unlikely to be prevented in the immediate future by a reasonable increase in staffing or the provision of other positive supports;
6. Justification for the use of the procedure that identifies the imminent risk of serious injury due to the person's interfering behavior if the procedure were not utilized;
7. Documentation of the persons consulted in creating and maintaining the current positive support transition plan;
8. Documentation of approval by the person's expanded support team of the submission to the committee of the request for use of a prohibited procedure; and
9. Additional documentation as requested by the committee.

The EPRC bases its determination upon the documentation provided above. The EPRC includes in their approval recommendation to the Commissioner the additional terms or conditions a license holder must meet specific to their approval. The Commissioner or her/his designee has the final decision on whether to approve the use of the procedure. Notifications of the Commissioner's decision are sent to the team. See the [Request for the Authorization of the Emergency Use of Procedures form (DHS-6810D)](#) for more information.

Appendix A: Frequently Asked Questions

What do Positive Support Strategies mean?

A "positive support strategy" is a strengths-based strategy based on an individualized assessment that emphasizes teaching a person productive and self-determined skills or alternative strategies and behaviors without the use of restrictive interventions

What are the goals of the PSR?

The PSR supports several goals that represent the latest developments in the field of disability services. These goals include:

- Promote community participation, person-centeredness & inclusion in the most integrated setting
- Focus on creating quality environments
- Ensure collaborative development of positive support strategies
- Increase skills and self-determination of people receiving services
- Improve the quality of life of people receiving services
- Ensure people are free from humiliating and demeaning procedures
- Eliminate the use of aversive and deprivation procedures
- Create a consistent set of standards for providers across service settings.

What is the effective date of the PSR?

The rule became effective on August 31, 2015

As a DHS license holder, do I need to meet the requirements of the Rule?

The rule applies to all DHS license holders who provide services to a person or child with a "developmental disability or related condition."

Is there a definition of "developmental disability or related condition" that can help me determine if I must comply with the rule?

The PSR uses the definitions for these terms that are found in Rule 9525.0016, subpart 2, governing case management services to persons with disabilities. Please read those definitions to become familiar with what health conditions the PSR covers.

In general, for a person to have a "developmental disability," they must be diagnosed as having an intellectual disability that substantially limits their cognitive functioning and other skills, including communication and self-care, prior to their 22nd birthday.

In general, for a person to have a "related condition," they must have a condition that closely resembles a "developmental disability" and requires treatments or services similar to those required for persons with developmental disabilities. Examples of closely related conditions include cerebral palsy, Prader-Willi syndrome, and autism spectrum disorder.

Mental illness as defined under Minnesota Statutes, section 245.462, subdivision 20, or an emotional disturbance, as defined under Minnesota Statutes, section 245.4871, subdivision 15, are not "related conditions." For example, attention deficit hyperactivity disorder (ADHD) is not a "related condition."

However, an individual might have multiple diagnoses (chronic mental illness and autism) and so the rule would apply.

So those are the definitions of "developmental disability or related condition" referenced in the PSR, but how would I know that a specific person receiving services from me actually meets one of those definitions?

If you are providing services to someone under a 245D or Home and Community Based Services (HCBS) license, then that person is automatically covered by the PSR, regardless of their diagnosis, and all services your program provides to that person must comply with the PSR.

If you are delivering services to someone under any other DHS license, there are several possible ways you might know if he/she meets the definition:

1. The person, or their legal guardian, may have told you. If you are providing services to a child, the parent or legal guardian may have told you.
2. You know that the adult or child receiving services from you is on a Developmental Disability (DD) waiver or has a DD case manager.
3. There may be medical or health information in the adult or child's client/service file, treatment plan, Coordinated Service and Support Plan, or Individualized Education Plan (IEP) that indicates the adult or child may have a "developmental disability or related condition."

In general, if you have information that suggests a person you are serving meets the definition of "developmental disability or related condition," as defined in the PSR; you should follow up with the person (or their legal guardian) and discuss the PSR rule and definitions with them. You should then document the outcome of that follow up, including whether the person meets the definition of "developmental disability or related condition."

I am a DHS license holder but I do not provide services governed by 245D (HCBS). I have professionals on my staff who are qualified to conduct a diagnostic assessment. Can my staff person determine if someone meets the definition of "developmental disability or related condition"?

Yes. The staff person should also document whether, because of the assessment, the person meets the definition of "developmental disability or related condition" so that your program can comply with the PSR if applicable.

How does the PSR affect my program/service? What are the key requirements of the PSR?

If you are serving a person/child with developmental disabilities or a related condition, then there are requirements for your program for staff training, for documentation, for interactions with the person/child, and for compliance and reporting. The requirements of the PSR can be found in Minnesota Rules, chapter 9544 (https://www.revisor.leg.state.mn.us/rules/?id=9544&view=chapter).

In general, there are seven key requirements that license holders must follow:

- Maintain a Policy on the Emergency Use of Manual Restraint
- Develop and Document Positive Support Strategies For Every Person to Whom the PSR Applies
- Prohibit the Use of Restrictive Interventions

- Conduct Functional Behavior Assessments
- Develop Positive Support Transition Plans
- Report Certain Incidents Using the Behavior Intervention Report Form
- Ensure certain Staff Qualifications & Training Are Met

Will DHS Licensing staff be monitoring for compliance with the PSR?

Yes.

If I am serving a person with a "developmental disability or related condition" and my program has not complied with all the requirements of the PSR, will DHS Licensing staff issue me a citation or correction order?

DHS Licensing staff will be reviewing license holder records for evidence that the program complied with the training, documentation and programming requirements of the PSR

Will variances be granted to the Positive Supports Rule?

The Department of Human Services will not grant a variance to allow the use of a prohibited procedure as defined in the PSR. Other variances will be considered on an individualized basis and consistent with DHS authority and guidance provided in statute. (E.g. Pursuant to Minnesota Statute, section 245A.04, subdivision 9, Human Services Licensing Act, the commissioner may grant variances to rules that do not affect the health or safety of persons in a licensed program if certain conditions are met).

If I want to request a variance, to whom do I send it?

You may submit your variance to your DHS licensor using the approved variance request form (DHS-3141).

PSR Training-Related Questions

Does this training requirement apply to me?

If you provide services under a DHS license and provide services for an adult or child with a "developmental disability or related condition," then the PSR training requirements apply to you and the services you provide.

If you provide services under a 245D Home and Community Based Service (HCBS) license, then the PSR training requirements apply to you. This is because every individual who receives your services is automatically covered by all the requirements of the rule, regardless of their diagnosis.

Why is training necessary?

The Positive Supports Rule represents a significant change in policy and, for some license holders, a significant shift in practice. Training is seen as essential to ensuring that all individuals who are involved in providing services have adequate skills and knowledge to provide safe and effective services.

What are the training requirements of the PSR?

The training requirements of the PSR will depend based on the person's level of responsibility and qualifications. If someone has multiple roles in the organization as described below, then the person may have to take more than one training.

In brief:

A. Staff who provide direct services to a person/child with a developmental disability or related condition and have responsibility for developing, implementing, monitoring, supervising or evaluating:
   a. Positive support strategies;
   b. A positive support transition plan, or
   c. The emergency use of manual restraint must complete 8 hours of "core training" before assuming their responsibilities, and 4 hours of refresher training applicable to their responsibilities;
B. Staff who develop positive support strategies for a person/child with a developmental disability or related condition must complete 4 hours of "function specific training" in addition to the core training before assuming their responsibilities and four hours refresher training applicable to their responsibilities. License holders, executives, managers and owners may also need to complete the 4 hours of function specific training if their duties involve the substance of the function specific training; and
C. License holders, executives, managers, and owners in nonclinical roles must complete 2 hours of management training before assuming their responsibilities. At a minimum, all controlling individuals listed on your license with DHS must complete this management training. A license holder, executive, manager or owner in a nonclinical role may need to complete "core training" and "function specific training" if s/he provides direct services, or develops positive support strategies, to a person/child with a developmental disability or related condition.

The training requirements should be completed as soon as possible.

Core Training (8 hours)
Core Training covers:

A. De-escalation techniques and their value;
B. Principles of person-centered service planning and delivery, and how they apply to direct support services provided by staff;
C. Principles of positive support strategies such as positive behavior supports, the relationship between staff interactions with the person and the person's behavior, and the relationship between the person's environment and the person's behavior;
D. What constitutes the use of restraint, including chemical restraint, time out, and seclusion;
E. The safe and correct use of manual restraint on an emergency basis;
F. Staff responsibilities related to prohibited procedures; why the procedures are not effective for reducing or eliminating symptoms or interfering behavior; and why the procedures are not safe;
G. Staff responsibilities related to restricted and permitted actions and procedures;
H. The situations in which staff must contact 911 services in response to an imminent risk of harm to the person or others;
I. The procedures and forms staff must use to monitor and report use of restrictive interventions that are part of a positive support transition plan;
J. The procedures and requirements for notifying members of the person's expanded support team after the use of a restrictive intervention with the person;
K. Understanding of the person as a unique individual and how to implement treatment plans and responsibilities; assigned to the license holder;
L. Cultural competence; and
M. Personal staff accountability and staff self-care after emergencies.

Function-Specific Training (4 hours)

Function-Specific Training covers:

A. Functional behavior assessments;

B. How to apply person-centered planning

C. How to design and use data systems to measure effectiveness of care; and

D. Supervision, including how to train, coach, and evaluate staff and encourage effective communication with the person and the person's support team.

Management Training (2 hours)

Management Training covers:

A. How to include staff in organizational decisions;

B. Management of the organization based upon person-centered thinking and practices and how to address person-centered thinking and practices in the organization; and

C. Evaluation of organizational training as it applies to the measurement of behavior change and improved outcomes for persons receiving services.

Annual Refresher Training (4 hours)

Staff providing services to a person/child with a developmental disability or related condition, which includes all staff working for a program licensed under 245D, are required to complete four (4) hours of refresher training on an annual basis. The Refresher Training covers topics from the Core Training and Function-Specific Training. The rule requires staff to complete trainings that are applicable to their responsibilities.

Can the license holder count equivalent trainings that staff and others have already completed and that are on the topics of the PSR (e.g. de-escalation techniques)?

Yes. The goal of the required training is to ensure competency of staff in the knowledge and skills outlined in the PSR. However, you will want to carefully document those equivalent hours of training and why you think they meet the requirements of the new rule. For both the Function-Specific Training and the Management Training, the rule allows for counting "equivalent training approved by the commissioner" only if the equivalent training was completed within the previous 12 months.

What is meant by "demonstrated competency" in the PSR?

The PSR requires that the license holder ensure that staff demonstrate their competency, through testing or observation, to perform positive support strategies that are 'relevant to the primary disability, diagnosis or interfering behavior of the person.' These competencies will vary from one staff to the next.

Do I need to document that personnel have completed the trainings? What needs to be documented?

The license holder is responsible for ensuring documentation of the completion of the Core Training, additional trainings, and competency testing or assessments. The following information should be documented for each staff in the personnel record: (1) subject area(s); (2) date(s) of training; (3) the number of training hours per subject area; and (4) the name and qualifications of the trainer or instructor. DHS-6810E is a sample training documentation form.

How are license holders and their staff to get the training required by the rule?

Each license holder is responsible for getting the training themselves. DHS is working with the College of Direct Support at the University of Minnesota to ensure appropriate and accessible training content is available to license holders.

The training section of the PSR talks about a "qualified individual" delivering the required trainings on the PSR. What is the definition of a "qualified individual"?

"Qualified individual" (referenced in the training section of the PSR) is not defined in the rule, so the license holder must determine who is a "qualified individual" for training purposes.

If we do not have an individual with a developmental disability or related condition now in our care, but might someday, do we have to complete the training?

If you are currently serving someone with a "developmental disability or related condition," then the PSR applies to your service to that person/child and you must comply with the PSR in its entirety and as soon as is practically feasible.

If you are not currently serving someone with a "developmental disability or related condition," you must come into compliance with the PSR prior to providing services to them.

Remember, if you are providing services under a 245D HCBS license, then each person you provide services to is covered by the PSR and you must comply with the PSR in its entirety and as soon as is practically feasible.

Appendix B: Physiological (Medical) Issues to Consider

Adapted from Guidelines for Supporting Adults with Challenging Behaviors in Community Settings (PDF)

Appendix B.1: PAIN*

Everyone experiences pain in a unique way. However, a person with a developmental disability who has impaired communication skills (or is possibly nonverbal) may at times communicate his/her pain through dangerous or socially inappropriate behaviors.

QUESTION	RESPONSE
What causes Physical Pain?	• Chronic medical conditions • Recent, non-visible injuries • Untreated dental problems • Emotional and interpersonal problems
Who May Be More Prone to Behavioral Expressions of Physical Pain?	• Those who have an expressive language disorder • Persons with impaired cognitive abilities • Infants and children • People with idiosyncratic behaviors (i.e., a person with Autism)
Clues That Physical Pain is Causing Behavioral and Emotional Problems	• Aggression and self-injurious behaviors (such as head • banging or self-biting) • Agitation and restlessness, especially at night • Temper tantrums (caused by frustration due to an inability to verbally communicate) • Various attention seeking behaviors • Feeding and eating problems (i.e., general food refusal or refusal of firm textured foods) • Holding a body part (such as gripping one's cheeks) or hitting a body part (such as the stomach)
What Approaches Can Be Used to Increase the Person's Comfort When Experiencing Pain?	• Seek a through health evaluation • Prepare the person adequately before the healthcare visit so that the exam can be completed. • Remember, regardless of a person's level of disability she is a partner in his/her own healing – respect that. • Ask primary health care provider about the appropriateness of prescription or over the counter pain reducing medications for temporary relief.

	• Show patience and empathy (reassurance that the person can understand).
	• Speak slowly and softly.
	• Softly touch where and when appropriate. (For example, massage feet, legs, back, or shoulders).
	• "De-stress" the environment by turning on soft music, eliminating loud noise, and decreasing stimuli.
	• Be sensitive to non-verbal communication, such as body posture, facial expression, words, or sounds.
	• Respond in a caring, non-judgmental way.

Appendix B.2: MEDICAL CONSIDERATIONS IN THE APPROACH TO PROBLEMATIC BEHAVIOR

Listed by Body System

GENERAL CONSIDERATIONS

1. **Pain**
   a. Pain can precipitate virtually any behavior, the two most obvious of which are self-injurious and aggressive behaviors. When a person develops a behavior in which he/she is hitting a particular body part, it is wise to examine that body part. Previous trauma may be a precipitator of behaviors related to pain. A person could become aggressive when they are experiencing pain because of their lack of understanding of what pain is and how to seek relief.
      i. Behaviors such as agitation, pacing and running away can also be precipitated by pain. Persons with pain from any source may also display a variety of sleep disturbances.
      ii. Also to be considered when evaluation such behaviors is the phenomenon of counter stimulation. The dentist uses this when injecting lidocaine into the mouth. The dentist will shake your lip to provide counter stimulation. This provides additional stimulation for the nerves and the brain to process, thus lessening the experience of pain at the injection site. The person with DD may be providing him or herself with some counter stimulation, potentially far from the site of the pain, in an effort to gain relief from the pain or discomfort.
2. **Medication Effects, Medication Side Effects and Medication Toxicity Medication effects, side effects, and toxic effects**
   a. These effects can precipitate many behaviors with the most common being aggression and agitation or motor restlessness (sometimes called hyperactivity). Self-injurious behaviors and altered sleep patterns can also be related to medication effects. The direct care staff must be informed when making any medication change for the person, indicating to the staff that observation is required and any changes in the behavior of the person need to be reported.
      i. Many of these behaviors will be due to a direct effect of the medications. The most obvious example of this would be over-sedation from the use of a medication to sedate a person.

      ii.   Side effects of medications precipitating behavior problems are a common phenomenon. Akathisia is a commonly recognized example and is generally expressed as agitation and/or motor restlessness. Sedation from medication not used for sedation is another example.

      iii. Toxic effects also may precipitate behaviors. Most frequently, these effects result in an altered sensorium and loss of coordination. The person may appear "drunk" or "ill".

      iv. Finally, remember that one medication may affect another medication and may cause any of the above effects.

NEUROLOGIC EFFECTS

1. **Headaches**
   a. The expression of headache pain may be through many behaviors, but should be considered when head-banging or hitting behaviors occur.

2. **Seizures**
   a. The relationship between seizures and behavior is an exceeding important one. People diagnosed with temporal lobe seizures may have ictal, postictal and interictal aggressive behaviors.

      i.   Ictal (seizure) aggression may be manifest as unpredictable outbursts of rage or aggression. Unilateral motor manifestations of the seizure may precede the aggression, as may autonomic signs.

      ii. Attempts to strike out by the person may occur while the individual is disoriented and unable to recognize people around them or the situation they are in and even as caregivers are attempting to provide aid to the person. This is not unique to individuals with ID/DD and requires a calm and reassuring presence by responders and supports.

      iii. During acts of interictal aggression, the person is alert and attentive. All of the other signs of seizure activity are absent.

Between seizures the person may become angry at seemingly trivial events and may experience an urge to hit someone. In addition, these temporal lobe seizures may precipitate a psychotic state in that the person, leading to other behavior issues. Most often an individual will display a characteristic pattern of behavior and response to their seizures and they should obtain a good history and assessment from a qualified medical professional to know what to expect and how best to manage that with the individual at all phases.

Ictal aggression also occurs with non-convulsive frontal lobe seizures. Common manifestations of these seizures include repetitive, bilateral arm motions that result in striking items in the environment, including persons. A blank stare or "wild" facial expression, grimacing, teeth clenching, intense vocalizations, and occasionally biting or spitting may accompany these. Autonomic signs are also seen. These seizures often occur nocturnally, awakening the person. These episodes can follow anger or frustration or occur with provocation. They may last for a few minutes up to a half-hour. Frequently, the person seems to be physically stronger than usual during these involuntary outbursts.

Behavior changes also occur with other seizure types. Some persons experience an aura that may be accompanied by behavioral changes while others may have post-ictal behavior changes related to the area of the brain that is

affected by the resolving seizure activity. In all of these individuals, seizure control is the primary treatment modality for the prevention of seizure related behaviors.

> 3. **Meningitis/Encephalitis**
>   - a. Conditions of the central nervous system (CNS) may produce behavioral changes through the intermediaries of pain or fever (delirium) or by directly altering the person's sensorium. Infections may be accompanied by specific symptomatology.
> 4. **Dementia**
>   - a. The early onset of Alzheimer's and non-Alzheimer's types of dementia, particularly in the person with Down's syndrome (Trisomy 21), must be considered in the differential diagnosis of behavioral change. Equally important is the work-up of potential medical causes of dementia and delirium which must be addressed, as many of these may be treatable.

EYES

Cataracts and Glaucoma may produce behavior changes by altering the person's ability to see. These behaviors are primarily aggression and self-injury, although agitation is also fairly common. In addition, acute angle closure glaucoma can be quite painful, resulting in behaviors in response to the pain.

EARS, NOSE, AND THROAT

Otitis media, wax impaction, sinus infection and dental caries or abscess may alter behaviors through the intermediary of pain.

PULMONARY or CARDIOVASCULAR

The authors have not seen any pulmonary issues present with behavioral manifestations with any degree of frequency.

GASTROINTESTINAL

1. **Constipation/Fecal Impaction**
   - a. These two common problems in the DD population can precipitate a wide variety of behaviors ranging from rectal digging to aggression. In addition, the usual behavioral changes to be expected from persons with normal cognition, such as decreased appetite, may not occur in this population.
2. **Diarrhea**
   - a. The person may bring this problem to the attention of the staff by soiling, rectal digging or fecal smearing or flinging.
3. **Inflammatory Bowel Disease (Crohn's Ulcerative Colitis)**
   - a. These medical issues will have other symptoms, but if behavioral manifestations are present, will most likely be related to pain or diarrhea.
4. **Gastroesophageal Reflux/Hiatal Hernia**
   - a. The behavioral manifestations of these problems will most likely be related to pain. In addition, rumination may also be a related behavioral manifestation that can lead to significant illness and malnutrition, and in its extreme, death.
5. **Ulcer Disease (H. pylori)**
   - a. The primary behavioral manifestations sometimes accompanying this condition will be those related to pain.
6. **Intestinal Parasites/Pinworms**

    a. Pinworm infestations are the most common and are frequently manifested by rectal scratching or digging related to itching. Other infestations are much less common but also found in persons who display PICA behaviors, and typically manifest behaviorally as a result of pain or irritation.

GENITOURINARY

1. Dysmenorrhea and Urinary Tract Infection
   a. Behaviorally manifested through the intermediary of pain.
2. Premenstrual Syndrome and Premenstrual Dysphoric Disorder
   a. The behavioral manifestations are myriad and include irritability, agitation, and aggression. Occasionally self-injury will also be present. The key to diagnosis is the timing of these behaviors, occurring in the one to two weeks prior to menses, on a regular basis.
3. Vaginitis and Vaginal Candidiasis
   a. The primary behavioral manifestation of these issues will be related to unrelenting itching of the genital area. In less mobile and less verbal people, these manifestations may be simple irritability or agitation. More mobile individuals may engage in scratching of the genitals, and verbal individuals may complain of itching.

INTEGUMENTARY

Most issues here relate to itching of the skin. Behavioral manifestations include self-injurious behaviors such as rubbing, scratching, gouging and picking at the skin. Specific issues to look for are rashes such as contact dermatitis, eczema and psoriasis.

MUSCULOSKELETAL

The behavioral manifestations of fractures, bunions, degenerative joint disease and other podiatric issues are related to the intermediary of pain. A particular issue to note is that nail care is a difficult issue in this population. Problems related to ingrown toenails and toenails that are too long may also include refusal to walk or bear weight.

ENDOCRINE

The incidence of hypothyroidism is higher in persons with ID/DD than it is in the general public. In addition, some medications will predispose individuals to hypothyroidism. Individuals with hyper and hypo-thyroids may present with withdrawal and depression, lethargy, aggression, self-injury, agitation, sleep disturbance and changes in eating habits, just to list a few.

MENOPAUSE

Menopause can contribute to emotional strain on the individual. The physiologic changes that occur in women during the peri-menopausal phase of life can lead to significant behavioral changes. Some behaviors seen in women during the peri-menopausal phase may be attributed to this dramatic change in endocrine status, ranging from agitation and motor restlessness to aggression and self-injury to withdrawal and depression. Menopause may occur at a younger age in individuals with ID/DD, and therefore the effect of these changes may be missed.

HEMATOLOGIC

Many individuals with intellectual or developmental disability display pica behaviors. Sometimes these behaviors result in anemia, but at other times they result from anemia. All individuals who display pica behaviors should be screened for anemia when the behavior appears and at periodic intervals as long as the behavior exist.

SUMMARY

In summary, multiple medical issues may present with identical behavioral manifestations whether the result of the condition itself or secondary effect of pain, irritation or discomfort. The person's disability can make it more difficult for a medical practitioner to make an accurate diagnosis. A specialty physician or psychiatrist, with competencies working with people with disabilities, might be necessary. The key to diagnosis is maintaining a high index of suspicion and performing a history, physical examination and special studies as indicated. Medical illness should never be overlooked nor should its behavioral manifestations be treated with psychoactive agents or behavioral management without first addressing the underlying diagnosis and treatment of the condition.

Appendix C: Resources

National

Association of Positive Behavior Supports (APBS) (http://www.apbs.org): Provides information and training in positive behavior supports across various age groups, populations (children, developmental disabilities, mental health, and brain injury) and settings (schools, family, and community organizations). APBS provides presentations and webinars in topics related to PBS, as well as in-depth standards of practice.

The Adverse Childhood Experiences (ACE) Study (www.cdc.gov/violenceprevention/acestudy/index.html): Use to assess association between childhood maltreatment and adult well-being.

The Cochrane Collaboration (http://us.cochrane.org/cochrane-collaboration): An international not-for-profit and independent organization, dedicated to making up-to-date, accurate information about the effects of healthcare readily available worldwide. It produces and disseminates systematic reviews of healthcare interventions and promotes the search for evidence in the form of clinical trials and other studies of interventions.

Detoxification and Substance Abuse Treatment: A Quick Guide for Clinicians (PDF) (https://store.samhsa.gov/shin/content/SMA06-4225/SMA06-4225.pdf): This quick guide from SAMHSA provides ways for identifying symptoms of substance abuse and withdrawal as well as intervention strategies

Kansas Institute for Positive Behavior Support (KIPBS) (http://www.kipbs.org): Delivers training in positive behavior supports (PBS) and person-centered and wraparound planning. Online webinars are available, as well as research presentations in evidence-based practices.

Massachusetts Department of Mental Health Restraint/Seclusion Reduction Initiative (http://www.mass.gov/eohhs/gov/departments/dmh/restraintseclusion-reduction-initiative.html): Provides technical assistance and policy resources for children, adolescents, and adults in the mental health system. The RSRI offers safety tool assessments and an extensive resource guide in providing supports.

National Registry of Evidence-based Programs and Practices (NREPP) (http://www.nrepp.samhsa.gov/): A searchable online registry of 341 interventions that support mental health promotion, substance abuse prevention, and mental health and substance abuse treatment. All interventions that are included in NREPP have been voluntarily submitted, have met a set of minimum requirements, and have been assessed by independent reviewers.

Oregon Technical Assistance Cooperative (OTAC) (http://www.otac.org): Offers training in positive behavior supports for various populations, including the mental health community and autism spectrum disorder. Additionally, the Growing Resources Oregon (GRO) manual provides a comprehensive training for staff in person-centered approaches and positive behavior supports (PBS).

Pathways RTC updates (http://pathwaysrtc.pdx.edu/index): Provides information on the latest news and research regarding youth and young adult mental health issues.

Positive Behavior Supports Kansas (PBS – Kansas) (http://www.pbskansas.org): Provides information on positive behavior supports throughout various service systems (school, mental health, developmental disability). PBS – Kansas also provides links to the latest research in evidence-based practices in PBS.

Temple University Collaborative on Community Inclusion of Persons with Psychiatric Disabilities (http://www.tucollaborative.org): A research and training center dedicated to people with psychiatric disabilities participating fully in community life. Temple University Collaborative provides training, technical assistance, and best practices resources in various areas of community life. Numerous toolkits and publications are available in topics such as cultural competence, community integration, and self-determination.

University of Kansas, Setting Event Interventions (http://www.specialconnections.ku.edu/?q=behavior_plans/positive_behavior_support_interventions/teacher_tools/setting_event_interventions): Offers multiple interventions strategies that could be used with different types of setting events.

Minnesota

Minnesota Positive Support Practices Website (https://mnpsp.org/): This website was developed by DHS to provide more information about positive support practices and how to incorporate them into your work.

Minnesota Children's Mental Health Division Evidence-Based Practices Database (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_144791): Developed by DHS to guide decisions by parents and providers in planning for child and adolescent care. This tool is the first of its kind to be used in practice to address the question of what works for whom under what conditions. It incorporates data collected from rigorous review of scientific literature that suggest different techniques or strategies for treating children with various mental health disorders.

Minnesota's Adult Mental Health Resource Guide: Hope for Recovery (PDF) (http://www.namihelps.org/NAMIHopeForRecoveryBooklet2013.pdf): Published by the National Alliance on Mental Illness (NAMI) Minnesota. This is a resource booklet for navigating the mental health system in Minnesota.

Minnesota Brain Injury Alliance Consumer Guide (http://www.braininjurymn.org/consumerguide/index.php): An online guide with information to assist in making informed decisions about the quality of life following brain injury.

Minnesota/North Dakota Affiliate of the Alzheimer's Association (http://www.alz.org/mnnd/): Has been providing services, information, and advocacy for more than 30 years to people with dementia, their families and health care providers. Their mission is to eliminate Alzheimer's disease through the advancement of research; to provide and enhance care and support for all affected; and to reduce the risk of dementia through the promotion of brain health.

Community Workbook on Evidence-Based Prevention (PDF) (http://www.evaluatod.org/resources/evaluation-materials/FinalCommunityWorkbookonEvidence-basedPreventionNovember2012.pdf): Published by the Minnesota Department of Human Services Alcohol and Drug Abuse Division. It was created by Minnesota's Evidence-based Practices Workgroup (EBPW) to help local communities and prevention professionals answer some of the most common questions that arise about evidence-based programming.

Person Centered Thinking and Planning Training (http://rtc3.umn.edu/pctp/training/): Two 2-day interactive trainings available through the Minnesota Department of Human Services in partnership with the University of Minnesota's RTC on Community Living. Person-centered planning is changing the culture of service planning. The person is the primary focus when using person-centered planning, not the disability, service or some other issue. The 2-day Person-centered thinking training serves as a foundation for everyone who is involved in supporting people with disabilities. The 2-day Person-centered planning training goes into more depth on the planning process to support person-centered approaches. Person-Centered Thinking is a pre-requisite for the Person-Centered Planning training.

Support Development and Associates (SDA) (http://sdaus.com/): Provides PCT tools, articles, etc.

The Learning Community for Person Centered Practices (http://www.learningcommunity.us): Additional PCP tools are available on this website.

Other State Policies

Arizona Department of Economic Security, Division of Developmental Disabilities, Behavior Supports Manual https://des.az.gov/sites/default/files/media/Behavior-Supports-Manual-with-Links.pdf): This manual informs service providers of persons with developmental disabilities of the policies and procedures for behavioral interventions. This manual outlines permitted and prohibited techniques, staff training guidelines, and monitoring and oversight procedures.

Georgia Department of Behavioral Health and Developmental Disabilities Guidelines for Supporting Adults with Challenging Behaviors in Community Settings (PDF) (http://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/GuidelinesSupportingAdultsChallengingBehaviors.pdf): This document offers information in positive behavior supports for persons with mental illness and persons with developmental disabilities. The manual outlines steps and provides comprehensive examples for positive support practices.

Michigan Department of Community Health, Mental Health & Substance Abuse Administration Person-Centered Planning Policy and Practice Guidelines (PDF) (http://mn.gov/mnddc/positive_behavior_supports/pdf/person_centered_planning.pdf): This manual offers best practices for Michigan's service providers in person-centered planning for the developmental disability and mental health communities. It outlines person-centered planning as a basis for effective services and Positive Behavior Supports.

Vermont Department of Disabilities, Division of Disability and Aging Services Behavior Support Guidelines for Support Workers Paid with Developmental Services Funds (http://www.ddas.vermont.gov/ddas-policies/policies-dds/policies-dds-documents/behavior-support-guidelines): This is a policies and procedures manual for service providers and support staff of persons with developmental disabilities. The manual offers guidelines for person-centered planning and positive behavior supports, outlines prohibited procedures, and provides information on completing a functional assessment.

Multicultural Resources

Council on Asian Pacific Minnesotans (http://mn.gov/capm/): Centennial Office Building, 658 Cedar Street Suite 160, St. Paul, Minnesota 55155; Phone 651-757-1740

Minnesotans of African Heritage (http://mn.gov/cmah): 332 Minnesota Street Suite E1240, St. Paul, MN 55101; Phone 651-767-1750

Minnesota Indian Affairs Council (http://mn.gov/indianaffairs): Saint Paul Office 161 Saint Anthony Ave Suite 919, St. Paul, MN 55103; Bemidji Office 113 2nd Street NW Suite 110A, Bemidji, MN 56601

Minnesota Council on Latino Affairs (http://www.mcla.state.mn.us/Minnesota): One West Water Street, Suite 240, Saint Paul, MN 55107; Phone 651-767-1760

Appendix D: Psychotherapies with an Evidence Base

Adapted from the [National Institute on Mental Health](http://www.nimh.nih.gov/health/topics/psychotherapies/index.shtml)
(http://www.nimh.nih.gov/health/topics/psychotherapies/index.shtml)

Psychotherapy, or "talk therapy", is a way to treat people with a mental disorder by helping them understand their illness. It also can help patients manage their symptoms better and function at their best in everyday life.

Sometimes psychotherapy alone may be the best treatment for a person, depending on the illness and its severity. Other times, psychotherapy is combined with medications. Therapists work with a person or families to devise an appropriate treatment plan.

There is no "one-size-fits-all" approach. Some therapies have been scientifically tested more than others have. Some people may have a treatment plan that includes only one type of psychotherapy. Others receive treatment that includes elements of several different types. The kind of psychotherapy a person receives depends on his or her needs.

These are some of the more commonly used therapies:

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is a blend of two therapies: cognitive therapy (CT) and behavioral therapy. CT focuses on a person's thoughts and beliefs, and how they influence a person's mood and actions, and aims to change a person's thinking to be more adaptive and healthy. Behavioral therapy focuses on a person's actions and aims to change behavior patterns.

CBT helps a person focus on his or her current problems and how to solve them. Both patient and therapist need to be actively involved in this process. The therapist helps the patient learn how to identify distorted or unhelpful thinking patterns, recognize and change inaccurate beliefs, relate to others in more positive ways, and change behaviors accordingly.

Dialectical Behavior Therapy

Dialectical behavior therapy (DBT), a form of CBT, was developed to treat people with suicidal thoughts and actions. The term "dialectical" refers to a philosophic exercise in which two opposing views are discussed until a logical blending or balance of the two extremes— the middle way—is found. In keeping with that philosophy, the therapist assures the person that their behavior and feelings are valid and understandable. At the same time, the therapist coaches the person to understand that it is his or her personal responsibility to change disruptive behavior.

Interpersonal Therapy

Interpersonal therapy (IPT) is most often used on a one-on-one basis to treat depression or dysthymia (a more persistent but less severe form of depression). IPT is based on the idea that improving communication patterns and the ways people relate to others will effectively treat depression. IPT helps identify how a person interacts with other people. When a behavior is causing problems, IPT guides the person to change the behavior. IPT explores major issues that may add to a person's depression, such as grief, or times of upheaval or transition. Sometimes IPT is used along with antidepressant medications.

Family-Focused Therapy

Family-focused therapy (FFT) was developed for treating bipolar disorder. It was designed with the assumption that a patient's relationship with his or her family is vital to the success of managing the illness. FFT includes family members in therapy sessions to improve family relationships, which may support better treatment results.

Therapists trained in FFT work to identify difficulties and conflicts among family members that may be worsening the patient's illness. Therapy is meant to help members find more effective ways to resolve those difficulties. The therapist educates family members about their loved one's disorder, its symptoms and course, and how to help their relative manage it more effectively. When families learn about the disorder, they may be able to spot early signs of a relapse and create an action plan that involves all family members. During therapy, the therapist will help family members recognize when they express unhelpful criticism or hostility toward their relative with bipolar disorder. The therapist will teach family members how to communicate negative emotions in a better way.

Psychodynamic Therapy

Historically, psychodynamic therapy was tied to the principles of psychoanalytic theory, which asserts that a person's behavior is affected by his or her unconscious mind and past experiences. Now therapists who use psychodynamic therapy rarely include psychoanalytic methods. Rather, psychodynamic therapy helps people gain greater self-awareness and understanding about their own actions. It helps patients identify and explore how their non-conscious emotions and motivations can influence their behavior. Sometimes ideas from psychodynamic therapy are interwoven with other types of therapy, like CBT or IPT, to treat various types of mental disorders.

Light Therapy

Light therapy is used to treat seasonal affective disorder (SAD), a form of depression that usually occurs during the autumn and winter months, when the amount of natural sunlight decreases. Scientists think SAD occurs in some people when their bodies' daily rhythms are upset by short days and long nights. Research has found that the hormone melatonin is affected by this seasonal change. Melatonin normally works to regulate the body's rhythms and responses to light and dark. During light therapy, a person sits in front of a "light box" for periods of time, usually in the morning. The box emits a full spectrum light, and sitting in front of it appears to help reset the body's daily rhythms.

Expressive or Creative Arts Therapy

Expressive or creative arts therapy is based on the idea that people can help heal themselves through art, music, dance, writing, or other expressive acts.

Animal-Assisted Therapy

Working with animals, such as horses, dogs, or cats, may help some people cope with trauma, develop empathy, and encourage better communication. Companion animals are sometimes introduced in hospitals, psychiatric wards, nursing homes, and other places where they may bring comfort and have a mild therapeutic effect. Animal-assisted therapy has also been used as an added therapy for children with mental disorders.

Positive Psychology

Positive psychology is a branch of psychology that seeks to find interventions that lead to a satisfactory life instead of focusing on reducing symptoms of mental illness. For more information, see the University of Pennsylvania's Authentic Happiness website (https://www.authentichappiness.sas.upenn.edu/) or watch Martin Seligman's

TedTalk "The new era of positive psychology" (http://www.ted.com/talks/martin_seligman_on_the_state_of_psychology).

Appendix E: The Art of Authentic Person-Centered Planning

Adapted from the [Council on Quality and Leadership](http://www.c-q-l.org/resource-library/publications/cql-publications-for-free/quality-in-practice-guides/art-of-authentic-person-centered-planning) (http://www.c-q-l.org/resource-library/publications/cql-publications-for-free/quality-in-practice-guides/art-of-authentic-person-centered-planning)

Engaging in authentic Person-Centered Planning is fun, creative and synergistic work. This life planning process is rooted in what is most important to the person and involves the person directly with his or her community, network of connections, and close personal relationships to look at innovative ways to attain life goals and dreams.

The greatest reward in engaging in this process as a supporter is being able to witness a transformation occurring in a person's life when creative new directions and approaches are taken. To a person who has been supported in this process, there is nothing better than having a circle of collaborative supporters fully engaged with him or her as he or she moves towards the realization of specific life dreams and into a world of greater possibility for new goals to emerge. This is what most of us wanted to do when we entered the field of human services.

Authentic Person-Centered Planning: What it is

Authentic Person-Centered Planning processes have a number of common elements:

- The focus is entirely on the person, never the system.
- Numerous mainstream resources are unearthed, considered, researched and used. These resources are the ones that would be tapped first and foremost. For example, local community/neighborhood linkages, social programs, and assets; foundation grants; Community Development Block Grants; income generating ideas (jobs, micro-enterprise, self-employment); resources available from the person's place of worship; free cell/mobile phone programs; state and local housing programs; utility company discounts; extended family resources, if any; local business grants and collaboration; and many others.
- System resources are considered after the person's dreams, interests and gifts have been discovered and only in relationship to how those resources can be used to support people in achieving their dreams and contributing their gifts.
- System resources are not used to determine if something is feasible or can be reimbursed or as an approval or denial process.
- The process asks, "How can we do this?" rather than finding reasons why we cannot.
- The process and participation in the process depends more on our heart connections with the person than on our professional connections to the person.
- People are invited (as opposed to required) to attend.
- Many of the people attending are not paid to be there and might include neighbors, co-workers, friends, family, and community members from various affiliations.
- The group usually meets on some kind of regular basis to connect and follow-up and keep the energy and momentum moving forward.
- The space is usually not a conference room. Living rooms, church social halls or private rooms in restaurants are good choices. There is usually food to share and gatherings often occur at times other than Monday-Friday between 9:00 am and 5:00 pm.
- Notes are usually taken on big pieces of paper with colored markers, or pastels and chalks, often with images instead of words.
- Wacky ideas are often considered – and the rules of creative brainstorming are embraced.

- Not every dream and idea that is generated will become the ones that happen - the person's foremost priorities, dreams, and preferences become the focus of action.
- When and if a second Person-Centered Plan is completed, it will not look or feel anything like the first one, as the person's life will have changed and there will be new opportunities and challenges to explore.

Authentic Person-Centered Planning: What it is not

These examples indicate "Systems-Centered" not Person-Centered Planning:

- A case manager, service coordinator, and/or another professional who called and facilitated the meeting and services are the main focus vs. the person.
- The majority of (or all) attendees are paid professionals with titles. The meeting takes place annually in a meeting or conference room.
- Assessments are done ahead of time by titled professionals with recommendations.
- The meeting lasts for one or two hours, and forms and documentation are circulated and signed off on during that time.
- Programs, services and hours are the primary discussion, not a person's life dreams.
- Everything "wrong" with the person is pointed out and discussed.
- The person is nervous, uncomfortable, doesn't participate or is not present. Afterwards the documentation is filed away – every person served has one of these standard documents with their name on it in the official "case" file.

Engaging in authentic Person-Centered Planning vs. Systems-Centered Planning can be truly transformational to the person and supporters involved. This type of process can create major positive life changes for a person. It is an enjoyable and collaborative endeavor that can reap amazing rewards because it does not rely on a system to make change happen. Instead, it creates increasing opportunities for a person to be included in their local communities as a reciprocating member. The person's social capital (the value of one's networks), inclusion, and capacity grows leaps and bounds when his or her identification is with community, neighbors, friends and loved ones vs. a system of services.

Appendix F: Person-Centered Quality of Life Indicator Survey

Adapted from [Guidelines for Supporting Adults with Challenging Behaviors in Community Settings (PDF)](#)

The following interview questions are intended to provide a framework for gathering information about a person and what they value in life. These questions are meant to guide the discussion so as to understand a person's preferences within the required quality of life indicator categories, as well as the additional, more comprehensive categories.

Because it is the person who defines what a desirable quality of life is for him or her, and not others who assume what this should be, these questions should be asked in a way that allow the person to fully understand the question and answer in their own words to the best of their ability. As these questions are only meant to be a framework for creating quality of life indicators, additional clarifying questions are welcomed. The goal of this interview process is to gather information as much information about what the person's life currently looks like and what the person would like their life to be like as possible. Even if you know the answers to the questions, still ask the person as what you see may be different than what the person is experiencing. The purpose of asking the person how they are currently living and how they would like to be living is to gauge any disparities. Disparities should be considered when planning with the person in the future. These are very concrete, real-world questions to gather information about a person's personality and internal motivations, so it is important to try to understand why the question is being asked and how it relates to the category it has been placed under. For example, under the category "Social Integration", there is a question that says "what do you/don't you like about the people you work with at your job?" This question is not just asking this to see if they like their job, it's to gather information such as if the person likes working with the same people day after day or if they like to meet new people on occasion. Additionally, the question is asking if the person likes a job with minimal or maximal social interaction. To assist the interviewer in understanding possible indicators that can be realized with each set of questions, prompts for potential indicators are listed under the category in the left hand column.

The questions below serve only as a guide for the interview and should be rephrased as needed to increase the person's understanding of what is being asked and to elicit a response that accurately reflects the person's true feelings. For persons with limited communication skills, it may be helpful to interview whoever knows the person best, asking that person to respond the way the consumer would respond if he/she could communicate those ideas. Upon taking extensive notes of the answers to these questions, the task is create quality of life indicators within each category. As mentioned in the manual, there should be at least one to three indicators within each of the mandatory categories and it is recommended that there be one to three indicators within the optional categories.

Required Quality of Life Categories

Engagement in Preferred Activities
Examples of questions:
1. Where do you usually go during the day?
2. How do you like it there?
3. What do you like about it the most?
4. What do you not like about it the most?
5. What would you like to change about it? How? Why?
6. Are there any rules there that you think are unfair? (If so) What are they and how are they unfair?
7. What do you do there?

8. How do you like doing that?
9. Would you rather be doing something else? (If so) What?
10. How often do you get to do your favorite thing(s)? Would you like to get to do them more often?
11. What do you like about doing the things you like to do most?
12. If you could do anything you wanted during the day, what would that be?

Possible quality of life indicators gained from these questions:
- A list of activities that are considered their preferred activities and how often they would like to be engaged in those activities.
- If the person is exhibiting a positive affect, the amount of time they are currently getting to do their preferred activities may be adequate. If the person is feeling like they never get to do their preferred activities that should be discussed and a plan should be made, as this would contribute to an increased quality of life.
- Activities the person does not enjoy and should be avoided.
- Environment that are best for the person to enjoy their preferred activities.

Social Integration in the Community
Examples of questions:
1. How do you like the staff that supervises you during the day?
2. Is there anyone there, staff or others that you don't get along with? (If so) Tell me about how you might react if a supervisor does something you like and something you don't like.
3. If you could have any job you wanted, what would it be?
4. What do you like about your dream job?
5. Tell me about the people you usually see during the day? Have you met anyone new lately?
6. Do you like meeting new people?
7. Do you like talking and working with others?
8. Who are your best friends? Do you get to spend enough time with them?
9. Do you have a boyfriend/girlfriend? (If so) Do you get to spend enough time with him/her?
10. Is there something you'd like to do with your friends but can't? (If so) What? Why?
11. Who are you closest to in your family? Do you get to spend enough time with them?

Possible quality of life indicators gained from these questions:
- Types of management styles that suit the person in an employment or habilitation environment and how does the person respond to supervision they like or dislike.
- Components of employment that the person would enjoy.
- How much social stimuli should be in the person's place of employment. Should there be a lot of social interaction at their job and what is the optimal number of co-workers/new people the person is interacting with throughout the day.
- Frequency the person should be seeing their close friends/family or a significant other and what they like to do with them.

Physical Integration
Examples of questions:
1. How do you feel about where you live?
2. What do you like about where you live?
3. What do you not like about where you live?

4. What would you like to change about where you live?
5. Would you rather live somewhere else? (If so) Where? Why?
6. If you could live anywhere you wanted to, where would that be?
7. Does someone live with you? (If so) How do you like living with him/her/them?
8. What do you like about whom you live with?
9. What do you not like about whom you live with?
10. What would you like to change about your roommates?
11. Would you rather live with someone else? (If so) Who?
12. How do you like the staff (or if home provider, give name) that helps you at home?
13. How do they treat you?
14. Is there any staff at your home that you do not like? (If so) Why?
15. What would you like to change about the staff (or home provider's name) that helps you?
16. Is there anything wrong about the house/apartment that you live in? (If so) What?
17. What do you like best about your house/apartment?
18. Are there any rules at your home that you think are unfair? (If so) What are they?
19. Is there somewhere you can go if you want to be alone? (If so) Where?

Possible quality of life indicators gained from these questions:
- Types of living situations (including supervision, number of roommates, location etc.) that are best for the person.
- Balance between social time, alone/group time at their place of residence and employment time.

Physical Health
Examples of questions:
1. What are some of your favorite physical activities?
2. How many times a week do you do something that is active?
3. Have you felt ill recently? How did you feel when you were sick and for how long did you feel sick? How do you act/what do you do when you are not feeling well?
4. Do you feel sick often? How often?
5. What kinds of foods do you eat?
6. Do you try to eat the foods that you know are good for you?
7. How do you feel physically today? Is today like any other day?

Possible quality of life indicators gained from these questions:
- A list of the person has preferred physical activities that they enjoy and should be engaging in for health reasons.
- How the person is feeling on a regular basis currently and how could they improve their physical health.
- Indicators that the person's physical health is declining or at a low point.

Positive Affect
Examples of questions:
- When you are happy what do you find yourself doing? Do you smile? Do you talk to others more?
- When was the last time you were really happy? Tell me about why you were happy and what happened.
- When was the last time you were really sad? Tell me about why you were sad and what happened.
- Do you think you are happy more often than you are sad?

- What are some other feelings you have felt recently? Mad, frustrated, anxious, excited, content? Tell me why you think you've been feeling those things.

Possible quality of life indicators gained from these questions:
- Signs and signals that a person is experiencing a generally positive or generally negative affect.
- Contributing factors for a person's positive/negative affect.

Optional Quality of Life Categories

Opportunities for Goal Attainment
Examples of questions:
- Does your employer set up employment goals for you? What was the last goal you made and the last goal you achieved?
- Are there goals created in your place of residence? What was the last goal you made and the last goal you achieved?
- Do you feel your goals are in line with what you would like to achieve?
- How often do you feel like you achieve a goal?

Possible quality of life indicators gained from these questions:
- Frequency and type of goals of the person.
- Are they reaching an appropriate number of goals to support feelings of accomplishment and self-worth?

Increased Independence
Examples of questions:
- Do you feel like you need help from others in completing certain tasks? What are those tasks?
- Are you currently getting help completing the tasks for which you'd like help?
- Are you getting help when you feel like you don't need it? When and from who?
- Have you recently learned a new skill that helps you be more independent? How did you learn it and do you feel like you are learning these types of things frequently enough?
- What are some things you'd like to learn to do so you can live more independently?

Possible quality of life indicators gained from these questions:
- Identify areas where the person needs help and identify if the person is living with an appropriate amount of independence in the other areas to fit their capacity and abilities.
- Identify if appropriate actions are being taken to allow the person a chance to increase their independence.
- Signs the person is currently learning at their fullest potential in a positive way.
- Identify other skills that will contribute to future increases of independence for this person.

Work Performance
Examples of questions:
- What was the last positive thing your supervisor told you? Has your supervisor mentioned anything that you could improve upon or change about your work performance?
- Do you feel you can keep up with the demands of your job? Do you ever feel overwhelmed or do you ever feel the job is too easy?
- Do you feel that you get more done at work than your co-workers sometimes? What do you think causes you to get more or less accomplished?

- Do you know of anything that would help you get more done at work?

Possible quality of life indicators gained from these questions:
- Identify how much the person usually gets done at work (in order to compare to numbers in the future)
- Identify strengths of the person at work and what are some areas for improvement.
- Identify if their current job is appropriate for their abilities.
- Identify any reasonable accommodations that could be made to improve the person's work performance.
- Identify things that hinder and improve their work performance.

Memory and Concentration

Examples of questions:
1. How long do you usually stay focused on one task at work without a break or starting a new task?
2. Do you think you take more, less or about the same number of breaks as your co-workers? How does the length of time of your breaks compare to your co-workers?
3. Are you able to work on some things longer than others? What types of things?
4. What did you have for breakfast this morning?
5. What did you do on (insert name of day that is two days previous of the current day)?
6. Tell me about something that happened last week.
7. Do you ever get frustrated with yourself when you try to remember past events? Tell me about the last time you were frustrated about this.
8. Do you ever get frustrated because you feel like you can't concentrate as much as you would like on a task? Tell me about that time and how you were feeling.

Possible quality of life indicators gained from these questions:
- Determine if the person seems to be happy with their ability to concentrate and remember past events.
- Gauge their ability to remember past events and concentrate on a single task.
- Establish things that contribute to increased concentration.
- Identify things they remember well and tasks in which they concentrate well.

Appendix G: Person-Centered Exploration and Discovery: Supporting Questions

Created by the Department of Human Services for the [Successful Life Project (PDF)](#)

Person Centered Exploration and Discovery: Supporting Questions

These questions are provided to assist you in gathering detailed information about a person as you get to know who they are, what they want out of life, and what supports work for them to achieve that life. This information can be summarized into a Person Centered Description, and related action items can form the basis for a Person Centered Plan. These questions are not meant to be done in an interview style. Information can be uncovered via different methods. Some individuals may not mid sitting and talking about these questions as a list, but most people like to have more informal interactions where the individual gets to know them via branching conversations. If receiving mentorship from SLP, we will be discussing more about this exploration and discovery approach in the course of that mentorship process.

Describe what people like and admire about the individual:

This section is divided into two sections, one for people supporting the individual to answer themselves and one for the answers of the individual.

- **Describe what people like and admire about this person:**
  - What do you and others like about this person?
  - What do you and others admire about this person?
  - What does this person get complimented about?
  - What has this person taught you? (about anything in life)
  - What do you like to talk about with this person?
  - How does this person contribute to his/her community?
- **Describe what people like and admire you:**
  - What do you and others like about you?
  - What do you and others admire about you?
  - What does you get complimented about?
  - What have you taught others? (about anything in life)
  - What do others like to talk about with you?
  - How do you contribute to your community?

Home

- **Current Living Arrangements**
  - Describe your living arrangements:
  - What do you like about his or her current living situation?
  - What do you not like about his or her current living situation?
  - Are routines around the home important to you? Describe these routines…
  - What do you like doing around the house?
  - What helps you have a good day when arriving home from work or school?
- **Likes**
  - Describe what you enjoys and list your interests:
  - How do you like to spend your free time at home?
  - What has been your favorite job or work around the house?
  - What hobbies do you have?
  - Do you have a favorite holiday? What is it? How do you celebrate it?

- o   What do you like to do at home in the Spring, Summer, Fall or Winter?
- **Dislikes**
  - o   Describe what you dislike:
  - o   What jobs or chores in the home do you avoid?
  - o   What activities in the home do you decline? Why?
  - o   What supports (daily living, medical, behavioral) do you disagree with?
  - o   What makes you sad? What makes you frustrated?
- **Important to**
  - o   List and describe what is most important to you from your perspective:
  - o   Are there any themes from answers in this worksheet that are most important to you?
  - o   What are things you don't want to live without?
  - o   What makes you most happy, most content or really enjoy your life?
  - o   Have you learned anything new around what's most important to you from other planning sessions or team meetings?
  - o   What types of environments do you enjoy (large, small, quiet, noisy, etc.)?
- **Important for**
  - o   Describe what is needed for you to be healthy and safe:
  - o   What about your routines (morning, work, afternoon, or evening) do others need to know that supports you to be healthy and safe?
  - o   What works best when you go to a doctor appointment?
  - o   What environmental factors help you stay healthy and safe?
  - o   Describe any supports that assist you in managing your medications or treatments.
  - o   Have you learned anything new from other planning sessions or team meetings?
- **Future Goals**
  - o   Describe what you want to accomplish in the future:
  - o   What do you want to learn?
  - o   What is something that you would like to purchase?
  - o   Where would you like to live? How would you like to be living?
- **Improve Independence**
  - o   What could improve your ability to be independent?
  - o   What would you like to do independently but are not doing right now or need support to do it?
  - o   What type of assistive technology would be a benefit? For what?
  - o   Are there environmental adaptations to consider? At home?
  - o   How could you make more choices and decisions? About activities? About finances?
- **Household Contributions**
  - o   What would improve your ability to contribute to your household?
  - o   What gets in the way of you being (more) productive around home or ATE?
  - o   What could you do in their home to contribute to the household?
  - o   What adaptive equipment needs to be purchased, maintained, or updated?

Relationships

- **People**
  - o   Who are the person's favorite people to be around at home, at work or at school?
  - o   Who does the person try to avoid? Why?
  - o   Who are the people, other than staff, that the person would like to be around?
  - o   How does the person keep in touch with his or her favorite people (visiting, letters, email, phone, online, etc.)?

- **Social Interaction/Communication**
    - What supports, if any, are needed while interacting with others?
    - How important are friends to this person? Do they have as many friends as they would like?
    - How does this person communicate his or her needs, wants, and emotions?
    - How do staff/others know this person is happy? What does he/she look like?
    - When this person gets angry, what he or she needs most is…?
    - If this person uses words to communicate are there supports needed to fully understand a request?
    - What does staff/others need to know about how this person communicates?

Community

- **Likes**
    - Describe what you enjoy and list your interests:
    - How do you like to spend your free time in the community?
    - Where are your favorite places to go around town? What about out of town?
    - Where do you have the most fun?
    - What do you like to do in the community in the spring, summer, fall or winter?
    - What types of environments do you enjoy (large, small, quiet, noisy, etc.)?
- **Dislikes**
    - Describe what you dislikes
    - What activities in the community do you decline in the home? Why?
- **Future Goals**
    - Describe what you want to accomplish in the future:
    - What places do you want to go to?
- **Spiritual/Cultural Considerations**
    - Describe any of your spiritual, religious, and/or cultural considerations:
    - What type of church or temple (or other) do you like going to?
    - Who are the people that you are connected to at your church or temple (or other)?
    - What type of church or temple (or other) did you grow up with?
    - Are these considerations different than family ideas?
    - Are there other spiritual or cultural events that mean something to you?
- **Needed Supports**
    - Describe any supports you need to participate in activities that are important to you:
    - Do you need to consider making more money to participate in activities that are important to you?
    - What type of staffing ratio is needed? Are specific staff characteristics wanted?
    - What type of transportation is needed? What supports are needed to be in a vehicle?
    - What types of skills are needed to do specific jobs?
    - What budget supports do you need?
    - What supports are needed for you to carry money?
    - Describe any adaptive equipment and related supports you need.
    - Are there any special clothing considerations for you?
- **Improve Independence**
    - What could improve your ability to be independent?
    - Are there other learning opportunities or education to be considered?
    - Are there environmental adaptations to consider? At school? In community?
    - How can you make more choices and decisions? About activities? About finances?

- **More Involved**
    - How could you be more involved in activities or events in his/her community?
    - What activities do you enjoy doing?
    - Are there groups or clubs you want to join? If so, what supports are needed for you to participate?
    - Do you know what activities are available?
- **Community Contributions**
    - What would improve your ability to contribute to your community?
    - Do you want to volunteer in your community?
    - Are there spiritual or cultural events/considerations that you may want to participate in?
- **Learning**
    - What do you need to learn?
    - What would assist you to be involved in your community?
    - What do you need to learn to work more independently?
    - Could you benefit from learning to create or manage a budget?
    - Are there current health and safety supports that you could learn, assisting in becoming more independent?
    - Have you learned from other planning sessions or team meetings areas where increased skill or knowledge would be beneficial?

Work

- **Current Employment/Alternative**
    - Describe your employment/alternative to employment program/school:
    - Does your job match your desires, strengths and interests?
    - Do activities and school programs match your desires, strengths and interests?
    - What helps you have a good day when at work?
    - Is there something at break or lunch time that is most important? If so, be specific.
    - What jobs or tasks should change?
    - How do you make money?
    - Are you making as much money as you want?
    - What does an average day look like? What should continue? What should change?
    - What jobs are bad matches?
    - What jobs do you like to do best?
- **Likes**
    - Who are your favorite people to be around at work?
    - What do you talk about when asked about work or school?
- **Dislikes**
    - Describe what you dislike:
    - What jobs or chores in the community do you avoid?
    - What supports at work do you disagree with?
- **Future Goals**
    - If you could have any job, what would it be?
    - Describe what you want to accomplish in the future.
    - What kind of job do you want?
    - Do you want to advance in your current job?
    - How do you ask to change jobs?
    - What would improve your ability to increase your income?
    - Are there new jobs you want to try?

- o Are you working as much as you want?
- o Are there job advancements to consider?
- o What type of adaptive equipment could assist in increasing job duties?
- o Do you want to learn about different jobs?
- o What gets in the way of you being (more) productive at work? Where are the barriers?
- **Important to**
  - o What is important to you about work?
  - o What's most important to you about your job?
- **Important For**
  - o Describe what is needed for you to be healthy and safe:
  - o What about your routines (morning, work, afternoon, or evening) do others need to know that supports you to be healthy and safe?
  - o What does the employment/alternative to employment environment need to consider to keep you healthy and safe?
  - o What environmental factors help you stay healthy and safe?
  - o Describe any supports that assist you in managing your medications or treatments.
- **Needed Supports**
  - o Describe any supports you need to participate in activities that are important to you.
  - o What type of staffing ratio is needed? Are specific staff characteristics needed?
  - o What type of transportation is needed? What supports are needed to be in a vehicle?
  - o What types of skills are needed to do specific jobs?
- **Improve Independence**
  - o What could improve your ability to be independent?
  - o Are there environmental adaptations to consider?
- **Community Contributions**
  - o What would improve your ability to contribute to your community?
  - o Do you want to see how other people make money?
- **Learning**
  - o What do you want to learn?
  - o What do you want to learn to have things that are important to you?
  - o What jobs have you asked to learn?
  - o What activities or crafts have you asked to learn?
  - o What jobs or activities have you indicated you'd like to try?
  - o What do you need to learn?

Are there areas of conflict between health and safety supports and what is important to this person?

- Are there things important to this person that is in conflict with his or her health and safety supports or being a valued member of the community?
- Is something important to the person that is not able to happen because specific health and safety supports are in place that prevents it from happening?

Appendix H: Traits of Positive Approaches

Developed by Charles Young, Minnesota Department of Human Services

For all persons served

1. Each person, regardless of behavior is assessed upon intake for autonomy level (self-care skills, communication, memory and concentration, social activities, work performance)
2. Care providers work to increase a person's autonomy using results of the assessment

If the person exhibits interfering/interfering behavior:

1. Attempt to determine the purpose of the behavior/symptom
   a. Medical assessment (Focus on medical issues first!)
   b. Diagnostic assessment
   c. Behavioral/environmental assessment
      i. Determine the trigger
      ii. Determine if target behavior is typically rewarded/reinforced
2. Create a positive support transition plan to assist a person learn positive skills, increase autonomy, regulate emotions
   a. Each approach in the support plan should teach a skill or reinforce desired alternative skills (the use of generic Differential Reinforcement of Other behavior (DRO) is unacceptable)
   b. Do not use punishment procedures
   c. Find ways to reward progress
3. Train staff to implement plan and teach skills
4. If behavior endangers self or others, implement emergency use of manual restraint as last resort when all other approaches failed
   a. Take great effort to ensure no one involved is injured
   b. Make sure to explain it was only done for protection
5. Emphasize data collection and reporting to professionals/support team that includes:
   a. Behavior exhibited
   b. Time of day
   c. Witness/staff involved
   d. Context, Triggers (Antecedents), Behavior, Consequence and/or
   e. Situation, background, assessment, recommendations
6. Monitor effectiveness of plan through three categories:
   a. Decrease in target behavior (mood, affect, personal appearance, attitude, speech, behavior, thought process, orientation, judgment)
   b. Effect on Quality of Life
      i. Changes in preferred activities
      ii. Changes in autonomy level
      iii. Changes in social integration in community
   c. Increase in adaptive behavior/skills such as those behaviors that are functionally equivalent to the interfering behavior.
7. Review progress – then review the plan; modify the plan if signs of effective treatment are not present
8. Involve the person in the assessment, planning and review processes!

Appendix I: Glossary of non-restrictive techniques

Adapted from [Guidelines for Supporting Adults with Challenging Behaviors in Community Settings (PDF)](#)

Non-Restrictive Methods for use in Positive Support Transition Plans

For Use in Positive Behavior Support Plans Technique
1. Positive reinforcement
2. Negative reinforcement
3. Extinction (excludes aggression and SIB)
4. Differential reinforcement of incompatible behavior (DRI)
5. Differential reinforcement of other behavior (DRO)
6. Differential reinforcement of alternative behavior (DRA)
7. Behavioral Contracting with Positive Consequences (Earning Extra Privileges)
8. Reinforced practice
9. Contingent observation
10. Response blocking or interruption
11. Restoration of environment
12. Non-contingent dietary management
13. Withdrawal to a quiet area
14. Brief Manual Hold (Less than 10 Seconds)

Positive Reinforcement

Positive reinforcement refers to the presentation of a stimulus or event (usually thought of as pleasant) following the desired response, resulting in an increase in the frequency, duration, or intensity of that response. Several methods that maximize the effects of reinforcement are listed below:

a. The functional nature of the reinforcer must be empirically established by demonstrating an increase in the desired behavior. Praise and approval may be powerful reinforcers for one person but may have no effect on another person who may respond only to tangible objects or edible reinforcers.

b. The reinforcer must be delivered as quickly as possible following the targeted response. Being paid once a month for arriving at work on time in a sheltered workshop is probably not adequate to maintain the targeted behavior of prompt arrival. Similarly, the reward of a pizza party at the end of a week for engaging in prosocial behavior the whole time will be inadequately reinforcing to modify the behavior.

c. Use of the name of the person while the reinforcer is being delivered and telling the person which behavior is being reinforced will serve to strengthen the relationship between response and reinforcer.

Examples of Positive Reinforcement

1. A person remains on task for only brief periods of time. The staff member begins giving a penny candy (a preferred treat) to the person when he remains on task for short periods of time. As the person remains on task more consistently, the candy is given contingent upon the person remaining on task for gradually longer periods of time.

2. A person is learning to ask for permission rather than demand that the music channel be changed. When the person is successful in asking politely, a staff member says, "That's very nice of you, I am proud of how nice you said that!" The person then becomes more skillful at politely asking for permission to adjust the radio channel.

Negative Reinforcement

Negative reinforcement is one of the most misunderstood behavioral principles. Negative reinforcement refers to an increase in the frequency of a response that has led to the removal of a stimulus or event (usually thought of as noxious or unpleasant).

A common error is to confuse negative reinforcement with punishment. The difference between the two operations is that punishment serves to decrease the rate of a specific behavior, typically by introducing an unpleasant consequence, whereas negative reinforcement produces an increase in the rate of a specific behavior, typically by the removal of an unpleasant consequence.

It is important to recognize that negative reinforcement is no different than positive reinforcement in its effects upon the behavior it strengthens, and thus the same considerations outlined under positive reinforcement apply here as well. The following points are also noteworthy:

a. The reinforcing nature of the removal of the stimulus must be empirically established by the demonstration of an increase in the target behavior.
b. The event/stimulus must be removed as quickly as possible following the targeted response.
c. Using the person's name while the event/stimulus is withdrawn and verbalizing to the person which behavior is being reinforced will aid in establishing the association between the behavior and the removal of the stimulus.
d. The treatment team must remember that the inadvertent application of this technique may serve to reinforce negative or problematic behaviors. For instance, if withdrawal is an approved procedure for an extremely aggressive person and he frequently becomes aggressive during work time, aggression is likely being negatively reinforced by removing him from the work situation.

Example of Negative Reinforcement

1. A person finds a particular task unpleasant and is permitted to terminate the task contingent upon asking for a break. In this example, appropriate communication (rather than aggression or self-injurious behavior, which may have worked in the past) is reinforced by the termination of the unpleasant task.

Extinction of Interfering Behavior that is not Dangerous

The procedure of extinction involves a discontinuation of the contingent relationship between a response and its maintaining consequences resulting in a decrease in the rate, intensity or duration of the response.

An extinction procedure requires that the reinforcers which normally maintain a response first be identified and subsequently no longer be available when the response occurs. In many cases, the reinforcer may be social or some form of attention. For some persons, attention in the form of social disapproval or even physical restraint may be maintaining an undesirable behavior. Further, it is not uncommon for expulsion from the classroom to be the reinforcer (negative reinforcement) of inappropriate "talking in class." Talking in class can be put on extinction, by ignoring it and not allowing the student to be expelled from the class. Extinction is most effective when used in conjunction with reinforcement for desirable behaviors. The conditions under which extinction may not be an appropriate procedure may include:

a. The reinforcer(s) maintaining the response cannot be identified.

b. It is not possible to discontinue the contingency between a response and its consequence. For example, stealing food (response) automatically produces extra food reinforcement.
c. The inappropriate response is likely to produce serious tissue damage to the person and/or other persons in the environment or is likely to result in the serious destruction of property.
d. The predictable extinction burst that follows non-reinforcement is likely to be so intense that it produces risk of life or limb.

Extinction procedures often produce a temporary initial increase in the rate and intensity of the response, or increase other inappropriate responses such as aggression. Extinction procedures should therefore be used:

1. Only when the expected initial increase in the rate, variability, and force of the response cannot reasonably be expected to be physically dangerous to any person or likely to result in property destruction.
2. Only in conjunction with the reinforcement of other, appropriate responses.
3. When the behavior to be extinguished is not physically harmful to anyone, or likely to result in the destruction of property.
4. When reinforcers have been independently identified and provisions have been made for the absolute suspension of the contingency between the reinforcers and the inappropriate response.

The person's treatment team is responsible for determining if the behavior placed on an extinction program is non-aggressive and not self-abusive. Although extinction is not be suitable for use as the sole intervention, it should be part of any overall program to treat inappropriate behavior; i.e. any program should include minimizing reinforcement for the problem behavior.

Differential Reinforcement of Incompatible Behavior (DRI)

DRI involves reinforcing a behavior that is incompatible with the identified target behavior. The target behaviors are ignored or not reinforced, whereas the incompatible behavior is reinforced. The person is not able to exhibit both behaviors simultaneously.

Ignoring, or otherwise removing the reinforcer for target behavior and assuring reinforcement for desired behaviors are the components of differential reinforcement. Ignoring behavior is more effective when reinforcement for incompatible behavior is delivered. Delivery of reinforcement for desired behavior must occur at a rate that is higher than the frequency of the target behavior. Some examples of interfering behavior and the corresponding incompatible behavior are shown below.

Interfering Behaviors	Incompatible Behaviors
- Out of seat - Lying on the floor - Throwing objects - Pushing in line - Unlocking a car door	- In seat - Sitting in a chair - Writing or reading - Standing in line with arms at side - Playing a video game

Differential Reinforcement of Other Behavior (DRO)

Differential reinforcement of other behavior is the delivery of reinforcement to the person when he is not exhibiting the interfering behavior(s). That is, the person is reinforced when he/she is engaged in any behavior other than the interfering behavior.

When possible, it is preferable to use DRI (instead of DRO) in order to teach a specific functional but incompatible behavior. In DRO, as contrasted with DRI, the person may be reinforced for any of several adaptive behaviors. As with DRI, in determining the frequency of reinforcement for desired behaviors, baseline data on the frequency of target/interfering behaviors must be available. Delivery of reinforcement for other behavior must occur at a rate that is higher than the frequency of the target/interfering behavior. DRO can also be used to enrich the environment without reinforcing the behavior identified for reduction.

Example of Differential Reinforcement of Other Behavior (DRO)

1. A person usually screams for his personal items to be brought to him. If the person does not scream for 15 minutes, a staff member brings to him something that he likes. This schedule may continue at 15-minute intervals or it may be extended by adding five minutes to each time interval, up to some designated maximum DRO time period (e.g., 30 to 60 minutes).

Differential Reinforcement of Alternative Behavior (DRA)

DRA involves the reinforcement of a specific alternative behavior instead of the interfering behavior. The interfering/target behavior is ignored or is not reinforced, whereas the alternative behavior is reinforced. DRA differs from DRI in that the alternative behavior does not have to be incompatible with the target behavior. As with DRI and DRO, the frequency of reinforcement for alternative behaviors is dependent upon the baseline frequency of interfering behavior(s). Delivery of reinforcement for alternative behavior must occur at a rate that is higher than that of the interfering/target behavior(s).

The example described earlier under "negative reinforcement" includes the method of DRA. In that example, the person learned to politely request a break to leave a non-preferred area. In this case, requesting a break is not incompatible with maladaptive forms of escape, such as aggression or SIB, but it can be learned as a more socially acceptable and effective means of escape. In other words, it can be learned as an alternative to aggression and SIB.

With all Differential Reinforcement schedules (DRA, DRO & DRI), functional equivalency is important. That is, finding another action that meets the person's needs is paramount for these procedures to have effect. Additionally, the schedule of reinforcement needs to be dense enough so the person actually earns the reinforcer. If a schedule reinforces a person's positive behavior infrequently, maintaining that behavior is unlikely.

Behavioral Contracting with Positive Consequences (Earning Extra Privileges)

This type of behavioral contract is a written specification of the goals, the replacement behaviors and target interfering behaviors, and the reinforcement contingencies for a behavior-change program. There are no provisions in this type of contract for restrictive consequences for target interfering behavior. The focus is entirely on the added privileges that the person may earn for his positive or replacement behavior. The contract is mutually negotiated between the person and the clinician. Best practice tells us this element – mutual negotiation – is extremely important. In many cases, the person who is the focus of the contract actually creates it – increasing ownership of the plan.

The contract clearly specifies the problem behavior, the appropriate alternative behaviors, and the positive consequences of the behavior, the criteria for success and the signatures of both parties involved. An example of a behavioral contract follows:

INDIVIDUAL'S NAME

PROBLEM: (Name of person) refuses to clean up his room.

TARGET BEHAVIORS: As his part of this contract, (name of person) agrees to:
      1. Clean his room by 9:30 a.m. each day.
      2. Contact a staff member for room inspection when room is clean.
      3. Promptly make any needed corrections following room inspection.

REINFORCEMENT SCHEDULE:
Successful completion of the above target behaviors on a daily basis will result in:
- An extra trip on Tuesday to the swimming pool.
- An extra weekly trip into town to eat at a restaurant.

Failure to complete the above target behaviors on a daily basis will result in:
- Not getting the extra trip on Tuesday to the swimming pool.
- Not getting an extra weekly trip into town to eat at a restaurant.

AGREEMENT STATEMENTS AND SIGNATURES:
I agree to follow the provisions of this contract by exhibiting the described behavior.
_____
(Name of person)

I agree to provide the consequences that are specified in this contract.
_____
(Staff name)

Reinforced Practice

Reinforced Practice is a procedure whereby a person is afforded many opportunities to practice and receive reinforcement for a behavior in his/her current skill set. This is done in order to ensure the retention of that behavior. Many positive behaviors that occur under normal circumstances take place infrequently. The person is, therefore, limited in the number of opportunities that he/she has to practice the behavior once acquired. The purpose of this procedure is to design a structured program in which the practice of such adaptive behaviors occurs frequently and the appropriate behavior is reinforced. Important to reinforced practice is the emphasis on creating opportunities for the positive behavior to occur. There should also be no coercion or requirement for the person to participate in these opportunities. This ensures the person views the opportunity in a positive light.

Example of Reinforced Practice

A person has mastered the skill of brushing his teeth. A maintenance program affords frequent opportunities to receive reinforcement for practicing this skill (once in the morning, once in the evening and once after lunch in the afternoon). This will increase the probability that he/she will retain it in their repertoire.

Contingent Observation

Contingent observation is a procedure whereby, contingent upon a specified interfering behavior, a person leaves an activity with staff for a brief time and is given opportunity to observe the appropriate behavior of other people in the group. The person remains in the room where training is conducted with a group. After a specified period of observation, not to exceed 30 minutes, and after remaining quiet for a specified period of time (e.g., 5-15 minutes) or after having indicated that he will behave appropriately, the person rejoins the group.

Contingent observation is recommended for situations in which an extensive program of planned activities exists. Furthermore, the level or quantity of disruptive behavior must be more than momentary. Brief or one-time occurrences of a behavior do not warrant the use of contingent observation since the contingent observation may provide reinforcement for the undesired behavior. Contingent observation should include the opportunity to demonstrate the preferred behavior and receive reinforcement immediately upon re-entering the activity.

Example of Contingent Observation

1. A person who, while participating in a group activity, exhibits an interfering behavior that disrupts that activity. The person is asked to leave the activity with staff and asked to sit on a chair to observe the appropriate behavior of the remainder of the group. In this manner, the person is provided with modeling of the appropriate behavior that is expected of him. Either prior to joining the group or immediately when he joins the group, the person is given an opportunity to perform the positive behavior – and is reinforced immediately after.

Caution must be used when utilizing contingent observation. For example, an individual who is non-compliant with the requirement of sitting and watching the others might gain attention, likely a positive reinforce, by attempting to escape the contingent observation. In addition, certain individuals might increase their inappropriate behavior in the group if contingent observation provides them with the opportunity to engage in higher rates of self-stimulation, or escape from a non-preferred activity. Some people might also increase their inappropriate behavior in the group if the activity provided by contingent observation is reinforcing.

Response Blocking or Interruption

Response blocking is the physical interruption of a specific behavior by interposing a barrier (a hand, forearm, etc.) to temporarily prevent motion. Response blocking is intended to prevent the normal consequence of a behavior when said consequence may be immediately reinforcing.

Response blocking does not involve extended grasping and holding of a person. By itself, response blocking does not promote adaptive behavior; hence, the procedure is usually used in conjunction with DRO, DRI, DRA, or some other reinforcement procedure.

Example of Response Blocking or Interruption

1. As an example of response blocking, a staff member would stand behind a seated person who regularly engages in head banging. When the person attempts to hit himself, the staff member quickly interposes his own hand between the person's hand and head, momentarily blocking the person's range of motion and preventing a blow to the head.

   A second staff member concurrently works with the person using reinforcement procedures to promote the person's involvement in some functional task incompatible with head banging.

Restoration of Environment

Restoration of the environment is a method used to have the disruptive person return the environment to the condition in which it was prior to the disruption displayed by that person. Restoration of the environment is not restitution in that the person does not have to modify the environment into a vastly improved state. The staff working with the person should use the least amount of prompting and guidance necessary to ensure that the person returns items to their original location and condition. Verbal prompts and facial expressions of staff should be "matter of fact" with no emotions displayed. Excessive talk and expression during this procedure can be reinforcing to the person who has disrupted the environment, leading to an increase in the disruptive behavior. The person is simply directed to rearrange those parts of the environment that he has disrupted.

In order to utilize restoration of the environment, the person must have the skills and physical ability necessary to restore the environment to its original condition. If the person is unable to perform full restoration, then partial restoration may be appropriate. Successful restoration is not to be followed by praise for the person. If praised, the person could learn to disrupt the environment so that he can have the opportunity to restore it and gain praise and social attention.

Non-Contingent Dietary Management

Non-contingent dietary management is simply the provision of a diet plan aimed at addressing the antecedents to specific target interfering behaviors. Usually the interfering behavior is associated with eating or digestion, such as pica, rumination, or food stealing. When utilizing non-contingent dietary management the medical staff must authorize the specific dietary management regimen that has been personized and the dietitian must be involved in the development and monitoring of the diet management plan.

Examples of Non-Contingent Dietary Management
- The use of peanut butter to decrease ruminating behavior.
- The use of extra portions to decrease the self-induced vomiting.
- The use of extra meal portions or additional snacks to decrease food stealing.

Appendix J: Qualified Professional Designation by License Type

According to Minnesota Rules, 9544.0020, subpart 47, "Qualified Professional" is defined separately for each type of service and license. Please note that professionals under D to J must also have at least two years of work experience in writing or implementing positive support plans or treatment plans and has demonstrated in an assessment approved by the commissioner that the professional is competent to develop and implement positive support transition plans. For purposes of this subpart, treatment plan means a written document prepared by a licensed health professional that includes a description of the precise treatment goals and the measures or services identified to accomplish them. The commissioner's competency assessment is found in the Continuing Care section of TrainLink titled PSR 100. The following occupations are qualified professionals for the specified services and settings:

A. For residential facilities for adults with mental illness governed under parts 9520.0500 to 9520.0670, a licensed mental health professional as identified in Minnesota Statutes, section 245.462, subdivision 18;

B. For residential mental health treatment for children with severe emotional disturbance governed under parts 2960.0010 to 2960.0120 and parts 2960.0580 to 2960.0700, a licensed mental health professional as identified in Minnesota Statutes, section 245.462, subdivision 18, clauses (1) to (6);

C. For sexual psychopathic personality and sexually dangerous person treatment programs governed under parts 9515.3000 to 9515.3110, a licensed mental health professional as defined in Minnesota Statutes, section 245.462, subdivision 18, or a licensed psychologist as defined in Minnesota Statutes, section 148.907.

D. For home and community-based services governed under Minnesota Statutes, chapter 245D, a designated coordinator as identified in Minnesota Statutes, section 245D.081, subdivision 2, paragraph (b); a behavior professional as identified in Minnesota Statutes, section 245D.091, subdivision 2; or a behavior analyst as identified in Minnesota Statutes, section 245D.091, subdivision 3;

E. For chemical dependency treatment programs governed under parts 9530.6405 to 9530.6505, a licensed alcohol and drug counselor as defined in part 9530.6450, subpart 5;

F. or detoxification programs governed under parts 9530.6510 to 9530.6590, a chemical dependency assessor as defined in part 9530.6510, subpart 3a;

G. For chemical dependency treatment programs for children governed under parts 2960.0010 to 2960.0120 and parts 2960.0430 to 2960.0500, an alcohol and drug counselor supervisor as identified in part 2960.0460, subpart 4; or an alcohol and drug counselor as identified in part 2960.0460, subpart 5;

H. For children's residential facilities governed under parts 2960.0010 to 2960.0120, including children's residential care, shelter care services, group residential settings, and transitional services programs, a program director as identified in part 2960.0020, subpart 57;

I. For child care centers governed under chapter 9503, a teacher as defined in part 9503.0032; a staff person who meets the qualification requirements in item A or D; or a person's case manager as required in Minnesota Statutes, section 256B.092, subdivision 1a, paragraph (e);

J. For foster family settings governed under parts 2960.3000 to 2960.3100, qualified staff from the county or private child placing agency; and

K. For the following settings and services, a person who meets the qualification requirements in item A or D; or a person's case manager as required in Minnesota Statutes, section 256B.092, subdivision 1a, paragraph (e):
   (1) Family child care governed under chapter 9502;
   (2) Family adult day services governed under Minnesota Statutes, section 245A.143;

(3) Adult day centers governed under parts 9555.9600 to 9555.9730;

(4) Adult foster care governed under parts 9555.5105 to 9555.6265;

(5) Child foster care governed under parts 2960.3000 to 2960.3340;

(6) Independent living assistance for youth governed under Minnesota Statutes, section 245A.22;

(7) Residential programs and services for persons with physical disabilities governed under chapter 9570; and

(8) Any other residential or nonresidential program licensed under Minnesota Statutes, chapter 245A.

Appendix K: Sample Positive Support Transition Plan

Clear Form

Minnesota Department of **Human Services**

DHS-6810-ENG   1-14

Positive Support Transition Plan

651-431-4300 or 866-267-7655

Attention. If you need free help interpreting this document, call the above number.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

កំណត់សម្គាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປຫີ້ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB3-0001 (3-13)

You must have version 9.1 or newer of Adobe Reader or Acrobat to use this form. Adobe Reader is available to download for free at http://get.adobe.com/reader/.

This information is available in accessible formats for individuals with disabilities by calling 651-431-4300, toll-free 866-267-7655, or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.

ADA1 (12-12)

Part A. Background Information

NAME	PMI	PROJECTED IMPLEMENTED DATE	PROJECTED ENDING DATE
John M.	00000000	2/1/2016	12/31/2016

PRIMARY/SECONDARY DIAGNOSIS
Intellectual Disability, PICA

FREQUENCY OF REVIEWS	DATE POSITIVE SUPPORT TRANSITION PLAN COMPLETED	DATE PLAN UPDATED
○ Weekly ○ Monthly ● Quarterly ○ Other	1/15/2016	N/A

SERVICE(S) AND TREATMENT PROVIDER(S) INVOLVED IN IMPLEMENTATION OF PLAN
Family, ABC Residential Services, XYZ Day Services, County Social Services

Prescribed psychotropic medication(s)

Medication	Intake frequency	PRN? (as needed)
Zyprexa	5 MG Daily	○ Yes ● No

Add medication

Part B. Target Interventions

Target Intervention(s) targeted for elimination (e.g. Emergency Use of Manual restraints (EUMR), mechanical restraints, seclusion, etc.)

	Intervention	Comments	
1.	Mechanical Restraint - Arm Braces	Arm Braces to prevent PICA	×
2.	Emergency Use of Manual Restraint (EUMR)		×

Add target intervention

Objective Data Collection of Target Interventions

How will you measure each Target Intervention throughout the course of this plan? Examples of methods would be:
Frequency count | Duration recording | Time sampling | Interval recording | Permanent products | Rating scale

	Intervention	Method	Comments
1.	Mechanical Restraint - Arm Braces	Duration recording	Staff will record the amount of time J.M. goes without the use of arm braces
2.	Emergency Use of Manual Restraint (EUMR)	Frequency count	Staff will track each incident of EUMR, as required by 245D

Desired and/or alternative positive support strategy/intervention(s)

Participation in leisure activities, household tasks, social interaction, playing ball with staff

Positive support strategy objective(s), including measurable criteria *(How will the intervention benefit the person?)*

Decrease attempts of ingesting non-edible/dangerous objects

Baseline data *(Number of targeted intervention(s) over at least two weeks of baseline data. If unable to acquire, document reasons)*

Braces are currently used continuously. Staff attempts to take the arm braces off every 15 minutes to allow J.M. to participate in activities.

Alternative interventions that have been attempted, considered, and rejected as not being effective or feasible

Manual restraint, splints, helmets, environmental changes and 2:1 staffing

Part C. Target Behaviors

Target Behavior(s) targeted for elimination *Defined in measurable and observable terms*

	Behavior	Comments
1.	Pica	Any instance of eating a non-edible

<div align="right">**Add target behavior**</div>

Objective Data Collection of Target Behaviors

Examples of methods would be: Frequency count | Duration recording | Time sampling | Interval recording | Permanent products | Rating scale

	Behavior	Method	Comments
1.	Pica	Frequency count	Staff will track the number of times John eats a non-edible item. Staff will also track the number of time John attempts to eat a non-edible item

Desired alternative action(s)

Eating only edible objects, participating in activities

Identified/hypothesized purpose of the Target Behavior(s)

Because John appears to attempt to eat inedible objects even though he is given access to 3 daily meals and several snacks throughout the day, ingesting inedible objects appears to provide automatic reinforcement of some kind.

Baseline data (pretreatment measurement of Target Behaviors). *Submit at least two weeks of baseline data, or if unable to acquire, document reasons.*

14 days of data collected in January 2016. Pica attempts = 18 instances. Actual consumption of inedible objects = 4 instances. Staff utilized EUMR 5 times to prevent actual consumption.

Reported and/or observed impact the Target Behavior(s) have on the person's quality of life

John's Pica behavior has impacted both his health and his social interactions. John has been hospitalized many times to remove dangerous objects. He is not able to access the community without intense supervision, which includes staff

clearing an environment before he arrives. It is considered life threatening for him to ingest dangerous objects and substances.

Part D. Crisis Support Planning and Response

Phase I. Calm/Ideal

Description of the person's affect/behavior when in Phase I

In all phases, John is searching or scanning for inedible objects to ingest. When he is calm, he tends to be engaged in activities with staff, such as playing ball, painting or manipulating sensory objects. John also enjoys rocking in his chair.

Strategies/methods used to support the person maintain Phase I. *Include use of Psychotropic Medication, counseling, emotional regulation training, skill building, preferred activities, etc.*

John takes psychotropic medication (see list in Part A). John also works on a discrimination goal daily in which he is asked to choose between an inedible object and a treat. He is rewarded with the treat when he chooses it. Staffing is currently at a 1:1 when at home. Staff is 2:1 on community outings. Keeping him engaged in preferred activities has proven to be successful in avoiding ingesting inedibles.

Phase II. Triggers

Description of identified triggers/antecedents for the person. *Situations, words, people, internal stimulus, decisions, critical periods, etc.*

Critical periods for John are: 1. when is left alone; 2. when staff are engaged in other activities; 3. when he is denied an inedible; and, 4. transition times. He appears to constantly scan for items to ingest and acts quickly when he sees an opportunity.

Methods to support the person to cope with or avoid triggers/antecedents (i.e. proactive strategies). *Proactive strategies are used before a known trigger/antecedent will be encountered.*

1:1 staffing, offering preferred activities, listening to music, putting arm braces on before a known trigger is encountered

Methods to support the person when encountering triggers/antecedents (i.e. reactive strategies). *Reactive strategies are used after encountering a trigger/antecedent.*

Informing John his has picked up an inedible, educating John on edible/inedible objects, redirection

Phase III. Escalation

Description of the person's affect/behavior when in Phase III

When it comes to ingesting inedible objects, John typically jumps straight from the Calm phase to a Crisis phase without an apparent change in affect. When he is denied an inedible, however, John has at times exhibited screaming, stomping his feet and physical aggression towards others in the form of slapping/hitting.

Support/intervention strategies during Phase III. *Specific de-escalation techniques such as offering PRN, calling a crisis line, etc.*

The foremost concern for John is the avoidance of ingesting inedibles. Staff are to physically intervene to prevent him from ingesting inedibles. After this happens, staff should redirect him to an alternative activity and clear the area of inedible objects. Staff should keep a calm demeanor as John appears to feed off the emotions of the staff. Staff should speak to John in a quiet voice while intervening

Phase IV. Crisis

Description of the person's affect/behavior when in phase IV

Importantly - eating an inedible object is a crisis for John. When he eats an inedible, he does not appear to change affect, so it may be difficult to know if he has ingested an inedible unless it was viewed by staff. If John is denied an object or staff take and object away, he may begin to scream, stomp his feet or physically aggress towards staff in the form of slapping and/or hitting

Intervention methods during phase IV. *Call 911, emergency use of manual restraint, etc.*

When John ingests an inedible, staff must call 91 so he can be checked out and typically have the object removed. Staff may need to implement an emergency use of manual restraint to obtain the item. If staff are able to remove the object from his hand or mouth, he can usually be redirected to another activity afterward.

Phase V. Recovery
Description of the person's affect/behavior when in phase V

John continuously scans for objects to ingest. His affect is typically calm. He can switch from a crisis stage to recovery and calm in an instant when redirected

Strategies/methods to support the person in recovery phase. *Debriefing, personal stories, talking to an ally, etc.*

Redirection from staff if an inedible object is ingested. He does like to listen to music and play ball with staff.

Part E. Quality of Life

Quality of Life Indicator(s) *Submit a minimum of two indicators, each from different categories*

	Indicator		Comments	
1.	Health, wellness and safety	▼	Afford John a safe and healthy life - avoid consuming inedible objects	×
2.	Control over supports	▼	Alone time without arm braces on (must be 'clean' environment)	×
3.	Community Membership	▼	John will participate in community outings 2 times per week in addition to his day program	×

Add Indicator

Objective Data Collection of Quality of Life Indicators
Examples of methods would be: Frequency count | Duration recording | Time sampling | Interval recording | Permanent products | Rating scale

	Indicator	Method		Comments
1.	Health, wellness and safety	Frequency count	▼	
2.	Control over supports	Duration recording	▼	Record the amount of time John had alone time without the braces on
3.	Community Membership	Frequency count	▼	Record the number of community outings John participated in

Quality of Life objective(s)

Due to his previous history in which he ingested an excessive amount of inedible objects, John's health is in jeopardy. His health may improve if he can go longer periods of time without ingesting an inedible object. The more self-control he exhibits, the more time time he can spend without his braces on and in the community.

Baseline for Quality of Life Indicator(s) *Minimum two weeks of data, or if unable to acquire, document reasons*

See target behavior for number 1. #2: John spent 2.5 hours a week without his braces on during a 14 day period. #3: John accessed the community 2 times per week in the 14 day baseline period

Part F. Authorship and Consent

NAME OF AUTHOR OF PLAN	POSITION/TITLE	
Bert R.	Program Director/Qualified Professional	
DESIGNATED COORDINATOR OR AUTHOR'S SIGNATURE		DATE
[signature]		1/31/2016
NAME OF CASE MANAGER	CASE MANAGER'S SIGNATURE	DATE
Adam W.	[signature]	1/31/2016

Statement of Understanding and Consent

By signing this document, I am consenting to the interventions described in this plan. Consent can be withdrawn at any time and will automatically expire 365 days after signing below. Future, substantial changes to the plan will require consent before implementation.

NAME OF PERSON RECEIVING SERVICES OR LEGAL REPRESENTATIVE	SIGNATURE OF PERSON RECEIVING SERVICES OR LEGAL REPRESENTATIVE	DATE
Samantha M.		1/31/2016

Appendix L: Sample Functional Analysis Screening Tool (FAST)

Client: _____ Age: _____ Date: _____

Informant: _____ Interviewer: _____

Please note: This screening tool has been developed as a resource for expanded support teams; the Department of Human Services does not require its use.

To the Interviewer: The Functional Analysis Screening Tool (FAST) is designed to identify a number of factors that may influence the occurrence of interfering and/or target behaviors. It should be used only as an initial screening toll and as part of a comprehensive functional behavior assessment of behavior. The FAST should be administered to several individuals who interact with the person frequently. Results should then be used as the basis for conducting direct observations in several different contexts to verify suspected behavioral functions, clarify ambiguous functions, and identify other relevant factors that may not have been included in this instrument.

To the Informant: Complete the sections below. After completing the section on "Informant-Person Relationship," read each of the numbered items carefully. If a statement accurately describes the person's behavior problem, circle "Yes." If not, circle "No."

Informant-Person Relationship

1. Indicate your relationship to the person:
   Parent _____ Teacher_____ Staff _____ Friend _____ Other _____

2. How long have you known the person?
   _____ Years _____ Months

3. Do you interact with the person on a daily basis?
   Yes _____ No _____
   a. If "Yes," how many hours per day? _____
   b. If "No," how many hours per week? _____

4. In what situations do you typically observe the person? (Mark all that apply.)

Self-care routines _____ Academic training _____ Meals _____ Skills training_____

Leisure activities _____ Work/vocational training _____ Evenings _____ Other_____

Problem Behavior Information

1. Problem behavior (Circle all that apply and describe.)
   a. Aggression _____
   b. Self-Injury _____
   c. Stereotypy _____
   d. Property destruction _____
   e. Elopement _____
   f. Other _____

2. Frequency: Hourly   Daily   Weekly   Less often

3. Severity: Mild: Disruptive but little risk to property or health _____
                     Moderate: Property damage or minor injury _____
                     Sever: Significant threat to health or safety _____

4. Situations in which the problem behavior is most likely to occur:
    Days/Times:

    _____

    Settings/Activities:

    _____

    Persons present:

    _____

5. Situations in which the problem behavior is least likely to occur:
    Days/Times:

    _____

    Settings/Activities:

    _____

    Persons present:

    _____

6. What is usually happening to the person right before the problem behavior occurs:

    _____

    _____

7. What usually happens to the person right after the problem behavior occurs?

    _____

    _____

8. Current treatments:

    _____

    _____

Part I. Social Influences on Behavior

1. The behavior usually occurs in your presence   Yes   No
   or in the presence of others

2. The behavior usually occurs soon after you   Yes   No
   or others interact with him/her in some way,
   such as delivering an instruction or
   reprimand, walking away from (ignoring) the
   him/her, taking away a "preferred" item,
   requiring him/her to change activities,
   talking to someone else in his/her presence,
   etc.

3. The behavior often is accompanied by other   Yes   No
   "emotional" responses, such as yelling or
   crying

If you answered "Yes" to item 1, 2 or 3, complete Part II. If you answered "No" to all three items in Part I, skip Part II.

Part II. Social Reinforcement

4. The behavior often occurs when he/she has   Yes   No
   not received much attention.

5. When the behavior occurs, you or others   Yes   No
   usually respond by interacting with him/her
   in some way. (e.g., comforting statements,
   verbal correction or reprimand, response
   blocking, redirection)

6. (S)he often engages in other annoying   Yes   No
   behaviors that produce attention.

7. (S)he frequently approaches you or others   Yes   No
   and/or initiates social interaction.

8. The behavior rarely occurs when you give   Yes   No
   him/her lots of attention.

9. The behavior often occurs when you take a   Yes   No
   particular item away from him/her or when
   you terminate a preferred leisure activity. (If
   "Yes," identify: _____)

10. The behavior often occurs when you inform the person that (s)he cannot have a certain item or cannot engage in a particular activity. (If "Yes," identify: _____)   Yes   No

11. When the behavior occurs, you often respond by giving him/her a specific item, such as a favorite toy, food, or some other item. (If "Yes," identify: _____)   Yes   No

12. (S)he often engages in other annoying behaviors that produce access to preferred items or activities.   Yes   No

13. The behavior rarely occurs during training activities or when you place other types of demands on him/her. (If "Yes," identify the activities: ____self-care   ____academic ____work   ____other)   Yes   No

14. The behavior often occurs during training activities or when asked to complete tasks.   Yes   No

15. (S)he often is noncompliant during training activities or when asked to complete tasks.   Yes   No

16. The behavior often occurs when the immediate environment is very noisy or crowed.   Yes   No

17. When the behavior occurs, you often respond by giving him/her brief "break from an ongoing task.   Yes   No

18. The behavior rarely occurs when you place few demands on him/her or when you leave him/her alone.   Yes   No

Part III. Nonsocial (Automatic) Reinforcement

19. The behavior occurs frequently when (s)he is alone or unoccupied   Yes   No

20. The behavior occurs at relatively high rates regardless of what is going on in his/her immediate surrounding environment

Yes   No

21. (S)he seems to have few known reinforcers or rarely engages in appropriate object manipulation or "play" behavior.

Yes   No

22. (S)he is generally unresponsive to social stimulation.

Yes   No

23. (S)he often engages in repetitive, stereotyped behaviors such as body rocking, hand or finger waving, object twirling, mouthing, etc.

Yes   No

24. When (s)he engages in the behavior, you and others usually respond by doing nothing (i.e., you never or rarely attend to the behavior.)

Yes   No

25. The behavior seems to occur in cycles. During a "high" cycle, the behavior occurs frequently and is extremely difficult to interrupt. During a "low" cycle the behavior rarely occurs.

Yes   No

26. The behavior seems to occur more often when the person is ill.

Yes   No

27. (S)he has a history of recurrent illness (e.g., ear or sinus infections, allergies, dermatitis).

Yes   No

Scoring Summary

Circle the items answered "Yes." If you completed only Part II, also circle items 1, 2, **and** 3.

Likely Maintaining Variable

1	2	3	4	5	6	7	8	_____ Social Reinforcement (attention)
1	2	3	9	10	11	12	13	_____ Social Reinforcement (access to specific activities/items)
1	2	3	14	15	16	17	18	_____ Social Reinforcement (escape)
19	20	21	22	23	24			_____ Automatic Reinforcement (sensory stimulation)
19	20	24	25	26	27			_____ Automatic Reinforcement (pain attenuation)

Appendix M: Setting Events Checklist

Adapted from the Escambia County School District Settings Events Checklist (PDF)
http://www.escambia.k12.fl.us/pbis/data/FBA/SETTING%20EVENTS%20CHECKLIST.pdf

Person receiving supports and services:		Person completing checklist:		
Interfering/Target behavior:			Date:	
Instructions: The list below includes events that could possibly increase the likelihood of an interfering or target behavior occurring. If an event contributes to the person's behavior, check the appropriate column to indicate when the event occurs in relation to when it contribute to the behavior. For longstanding influences, note only those that contribute to the current incident or behavior.				
Setting Event (by type)	Same Day	Day Before	Within Week	Long Standing
Physical				
Meal time change or meal missed				
Sleep pattern (including duration) atypical				
Medications changed or missed				
Appeared or complained of illness				
Appeared or complained of discomfort				
Allergy symptoms				
Seizure				
Chronic health condition				
Other (specify):				
Learning and self-regulation				
Specific disability (specify):				
Learning difficulties (specify):				
Short attention span				
Poor organizational skills				
Anger management problems				
Atypical sensory needs				
Other (specify):				
Social-emotional				
Anxious				
Irritable or agitated				
Depressed, sad or blue				
Experienced disappointment				
Refused a desired object or activity				
Reprimanded				
Fought, argued or had other negative interaction				
Difficulty with peer(s) (specify):				
Changes in environment (specify):				
Other (specify):				

Environment and routines				
Routine was altered; change in activity or order				
Routine was disrupted				
Change in caregiver/staff				
Absence of preferred caregiver/staff				
Was 'made' to do something				
Change in living placement (specify):				
Change in school or work				
Other (specify):				

Common Setting Events associated with Interfering/Target Behavior: Check any that contribute to the behavior identified above.

Environmental

☐	Crowded conditions	☐	Group instruction
☐	Barren environment	☐	Transitions
☐	Noise level	☐	Staffing patterns
☐	Heat/cold	☐	Being late for school/work
☐	Time of day	☐	Moving to a new school/home/work
☐	Music		
☐	Physical layout of environment		

Social

☐	Major life changes	☐	Certain individuals
☐	Fight with peers	☐	Losing a game
☐	Negative social interactions	☐	loss of a loved one
☐	Family divorce/discord	☐	Change in caregiver/staff

Physiological

☐	Not enough exercise	☐	Constipation
☐	Agitation due to emotions or physiological conditions (menses, medication change, medication side effects	☐	Hunger/thirst
☐	Sleep disturbances	☐	Illness
☐	Pain	☐	Mental illness
☐	Allergies	☐	Hypothyroidism
☐	Infections	☐	Injury

Appendix N: Policy Brief on the use of time out procedures

Developed by Charles Young, Minnesota Department of Human Services

Issue

M.S. 245D went into effect on Jan 1, 2014 and governs many home and community-based service providers. 245D prohibits the use of a number of procedures considered restrictive or aversive – including manual restraint (except in case of emergency), mechanical restraint, seclusion and time out. A number of advocacy organizations would like to see time out removed from the list of prohibitions – particularly the use of time out with children. They argue that time out is an evidence-based practice and can teach a child self-regulation or calming skills. DHS staff conducted a literature review on time out procedures to determine if they should be considered an evidence-based practice.

245D.02, subd. 34a. Time out. "Time out" means the involuntary removal of a person for a period of time to a designated area from which the person is not prevented from leaving. For the purpose of this chapter, "time out" does not mean voluntary removal or self-removal for the purpose of calming, prevention of escalation, or de-escalation of behavior; nor does it mean taking a brief break or rest from an activity for the purpose of providing the person an opportunity to regain self-control.

Summary

Many definitions of time out exist, which makes comparison and conversation problematic across disciplines and geography. "Time out" is even spelled three different ways: time out, timeout and time-out. It is difficult to count the number of meanings for the expression "time out", but here is a summary of different possible meanings:

1. Inclusion time out – time out from positive reinforcement (Ryan, Peterson and Rozalksi, 2007)
    a. Planned Ignore
2. Inclusion time out – removal of a person to an area where he or she can observe the rest of the room but is denied opportunity to participant (Ryan, Peterson and Rozalksi, 2007)
    a. Contingent Observation
3. Exclusion time out or Room Time Out – removing a person to a room away from ongoing activity
4. Seclusion time out – removing a person to a locked room (Ryan, Peterson and Rozalksi, 2007)
5. Restrained time out – using mechanical or manual restraint to immobilize a person (Ryan, Peterson and Rozalksi, 2007)
6. Time out from a high-requirement (Alessandri & Rivieri, 2013, Azrin, 1960) – taking breaks during intense activities/work
7. Time out/Delay of positive reinforcement (Azrin, 1960, Logue, 1988)) – the longer a person waits, the larger positive reinforcement they receive

Meanings for items 1-5 are each considered a form of punishment. Items 6 and 7 are both considered to be reinforcers. A review of the research on items 1-5 found no evidence that uses of time out for these purposes teach skills. There is evidence that these interventions are successful in reducing challenging behavior (Foxx & Shapiro, 1978, Lerman & Vorndran, 2002, Salend & Gordon, 1987, Alberto, Heflin and Andrews, 2002). So time out is an evidence-based practice - but not an evidence-based practice for teaching skills like calming or coping. Many sources and organizations, notably the American Academy of Pediatrics (1998 & 2012), maintain that the use of time out may be used as part of an effective disciplinary practice when positive methods have failed. None of these sources contend that any version of time out 1-5 should not be considered a form of punishment.

Time out, when used in the manner stated in items 6 & 7, is considered to be an evidence-based practice for teaching skills like patience and self-regulation (Azrin, 1960, Alessandri & Rivieri, 2013, Logue, 1988). These uses, however, are not considered prohibited under 245D and 9544. M.S. 245D prohibits meanings 1-5 (under definitions of "time out", "deprivation" and "seclusion"). These procedures may be utilized for up to 11-months in some cases when incorporated into a Positive Support Transition Plan (245D.06, subdivision 8).

It should be noted that the National Association of School Psychologists suggest taking a break or "time out" from situations when a person is upset or feeling angry (2002) to teach self-control. Use of "time out" in this manner does not appear to fit under definitions 1-7. Another definition may be required along the lines of "Time out from ongoing activity for purpose of strategizing, regrouping or calming". This definition would fit with one of the dictionary definitions of time-out, which reads: "a short period of time when you stop doing something so that you can rest or do something else," (Merriam-Webster).

Dangers of Time out

The dangers of using time out listed below are not unique to time out; they are common dangers in using any form of punishment:

- Restrictive and intrusive interventions, once implemented, may remain in place longer than needed (Iwata, Rolider and Dozier, 2009)
- Use of punishment can violate ethical standards and laws
- "Skills" learned may not transfer to settings outside of the area punishment is used (Lerman & Vorndran, 2002)
- Punishment can be shaming and dehumanizing (Lerman & Vorndran, 2002)
- The use of punishment has the potential for abuses by caregivers/therapists (Vollmer, 2002)
- Punishment can escalate challenging behavior or create new, unwanted behavior (Mazur, 2002, Spradlin, 2002)
- Prior experience with punishing stimulus can decrease sensitivity to that punishment (Lerman & Vorndran, 2002). This means that to be effective, intensity of punishment needs to increase.
- Punishment arouses emotion in both the punisher and the punished. The punisher may feel excited, satisfied or more aggressive impulses – which may cause the punisher to get carried away. The punished may feel pain, discomfort or humiliation, fear hate, a desire to escape or self-contempt – emotions which may be counterproductive to the situation and/or relationship (Funder, 2004)
- Punishment teaches about power. It can teach that powerful people get to hurt less-powerful people. For this reason, it has been found that parents who were abused as children may become child abusers themselves (Carter, 1994; Funder, 2004; Hemenway, Solnick & Widom, 1989)

The Case for Time out
- Evidence shows that time out, when used in combination with other positive strategies, can reduce uncooperative and aggressive behavior, and aids in the reduction of aggression, destructive behavior and non-compliance (Morawaska & Sanders, 2010)
- When compared to the use of attention, time out, attention plus time out or control, only time out contributes to compliance acquisition (Roberts, Hatzenbuehler and Bean, 1981)
- The American Academy of Pediatrics (2012) recommend using time out (removing positive reinforcement, ignoring, chair time-out, removal of privileges) as a last resort as part of a strategy for effective discipline

- Many sources recommend the use of time out particularly with children with ADHD (Fabiano, 2004, Bhargava, 2012, Roche, 2010, Moore, 2001) although medication management appears to have superior effects to behavioral treatment (MTA Cooperative Group, 1999)

The following points supporting a case for using and/or allowing time out are not specific to time out, but any use of punishment:

- Punishment is effective in reducing problem behavior and can change behavior permanently (Mazur 2002, Lerman and Vorndran, 2002)
- Punishment can decrease the incidents of challenging behavior faster than reinforcement techniques – which is useful when dealing with injurious behavior (Lerman & Vorndran, 2002)
- Using punishment may increase the incidents of wanted behaviors (Lerman & Vorndran, 2002, Johnston, 2006)
- Using punishment is considered important when it is difficult to determine the reinforcers contributing to the challenging behavior (Lerman & Vorndran, 2002)
- Punishment may be preferable to reinforcement-based treatments when problem behavior must be suppressed rapidly to prevent serious harm (Dura, 1991)

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Appendix O: Links to DHS Forms

Behavior Intervention Reporting Form (DHS-5148)

- https://edocs.dhs.state.mn.us/lfserver/Secure/DHS-5148-ENG

Positive Support Transition Plan (DHS-6810)

- https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810-ENG

Positive Support Transition Plan Review (DHS-6810A)

- https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810A-ENG

Instructions for Completing Positive Support Transition Plan (DHS-6810B)

- https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810B-ENG

Jensen Settlement (PDF)

- http://mn.gov/mnddc/meto_settlement/documents/METO_Settlement_Agreement_6-23-11.pdf

Minnesota Olmstead Plan (PDF)

- http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/dhs16_180147.pdf

Minnesota Statute 245D (PDF)

- www.revisor.mn.gov/statutes/?id=245D&format=pdf

Protection Standards

- www.revisor.mn.gov/statutes/?id=245D.06

Rule 40 Advisory Committee: Recommendations on Best Practices & Modernization of Rule 40 (PDF)

- https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6748-ENG

Sample Policies and Forms for Basic Supports and Services (PDF)

- www.dhs.state.mn.us/main/groups/licensing/documents/pub/dhs16_177363.pdf

Sample Policies and Forms for Intensive Supports and Services (PDF)

- http://www.dhs.state.mn.us/main/groups/licensing/documents/pub/dhs16_180212.pdf

Appendix P: References and Resources

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