ARTICLE 9

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DEPARTMENT OF ECONOMIC SECURITY

Your Partner For A Stronger Arizona

ARTICLE 9 - MANAGING INAPPROPRIATE BEHAVIORS

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ARTICLE 9 COMPETENCIES

1. Identify to whom Article 9 applies.

2. Identify 5 positive teaching techniques and strategies.

3. Identify when a team should consider developing a behavior plan, when they must meet to consider developing a behavior plan and when they must develop a behavior plan.

4. Determine when a strategy or technique must be reviewed and approved prior to use.

5. Identify and give examples of prohibited techniques.

6. Identify the monitoring requirements for the implementation of a behavior plan.

7. Identify who must review and who must approve those behavior plans including techniques that require review and approval.

8. Define an emergency, an emergency measure and describe when an emergency measure can be used.

9. Identify the reporting requirements for an emergency measure.

HISTORICAL PERSPECTIVE OF ARTICLE 9

In the mid 1980's, the Arizona Division of Developmental Disabilities was in the midst of deinstitutionalization. At that time, there were three institutional facilities operating in the State. The Arizona Training Programs in Phoenix and in Tucson had already begun relocating individuals into community based services. The population at the Coolidge facility was also rapidly declining. Planning had begun for Arizona to use Medicaid funding to support individuals with developmental disabilities which included compliance with the regulations of the Federal program.

The Division began to write administrative rules to restructure its practices to comply with the Federal program. Statutes on individual rights and behavioral methods were a significant part of this process and Article 9 was written to address both individual rights and the use of behavioral methods within DDD services.

The field of Behavioral Science was experiencing a shift in values as well as practice; specifically, in application within the disability community. The long tradition of aversive therapy and punishment within the institutional culture came into question. Federal regulations prohibited certain behavioral procedures and required oversight of others.

The Division drafted Article 9 in 1988 with representation from the advocacy community, particularly the ARC, the service providers across the State, people with disabilities and their families in order to meet Federal requirements.

Article 9 has had a significant impact in improving quality of life for many individuals. The sense of community has become the focus as many people, who at one time resided within the confines of an institution, now experience the fulfillment of value as contributing community members. The role of the service provider has shifted, from one of controller, to partner in support of individuals.

What is Article 9?

Who needs to follow Article 9?

Who is not required to follow Article 9?

POSITIVE BEHAVIOR SUPPORT

> "Positive Behavior Support is a set of processes that combine information from social, behavioral, and biomedical science and applies this information at the individual and/or systems level to reduce behavioral challenges and improve quality of life. Both systems-wide and individualized interventions used in PBS are empirically documented and can be used by a wide range of support providers." (http://www.apbs.org/about-apbs.html#mission)

Positive Behavior Support (PBS) is an approach to helping people improve difficult behavior that is based on four things:

A. An **Understanding** that people (even caregivers) do not control others, but seek to support others in their own behavior change process;
B. A **Belief** that there is a reason behind most difficult behavior, that people with difficult behavior should be treated with compassion and respect, and that they are entitled to lives of quality as well as effective services;
C. The **Application** of a large and growing body of knowledge about how to better understand people and make humane changes in their lives that can reduce the occurrence of difficult behavior; and
D. A **Conviction** to continually move away from the threat and/or use of unpleasant events to manage behavior.

The threat and/or use of unpleasant events minimize the dignity of the other person, often provoke retaliation, and sometimes may cause physical and emotional harm. One example involves overpowering someone and physically forcing him/her to do something he/she doesn't want to do. If he doesn't comply, he is forced and continues to be forced until he gives up fighting. A common and relatively minor example includes taking privileges away from a person when she misbehaves. However, even minor use of these approaches can be harmful in that it can take away from the dignity, autonomy, and sense of self-control of the other person. Equally important is that approaches like these that were once effective cease to work, caregivers tend to increase their level and intensity rather than decrease them. They may increase the length of time required in time-out, the amount of privileges taken away, or the tone of voice used.

PBS involves a commitment to continually search for new ways to minimize the use of these approaches. This does not mean parents or caregivers should be judged harshly if they occasionally resort to yelling. We all fall back on patterns of care giving that have worked for us in the past, especially when we are challenged by difficult behavior. PBS simply means that we, as caregivers, recognize the times when we have resorted to these types of measures, and continually seek to find alternatives that we can use next time we're challenged with similar behavior.

WHY DO WE NEED POSITIVE BEHAVIOR SUPPORT?

Many people with difficult behavior have been misunderstood and mistreated throughout our history. People with developmental disabilities, in particular, have been subject to a wide array of disrespectful, humiliating and even painful conditions in the name of "effective treatment". In recent years, however, there has been a growing body of research that demonstrates that even the most challenging behaviors can improve with the help of one or more of these approaches. The combination of these is the field called Positive Behavior Support.

This information was developed by the Arizona Positive Behavior Support project of the Institute for Human Development at Northern Arizona University, in collaboration with the Arizona Department of Economic Security, Division of Developmental Disabilities, June 2001.

INDIVIDUAL'S RIGHTS TO CONFIDENTIALITY

All personally identifiable records, reports and information pertaining to individuals served by the Arizona Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) are confidential.

Access to individual records and information shall be limited to specifically designated persons.

Personally identifiable information (*including audio-visual reproductions)* may not be released without prior written authorization from the legally responsible person, except as permitted by law, regulation or policy. (*In all cases, employees should refer requests to their supervisor, DES/DDD support coordinator, or review DES rules [R6-6-105.A.] for specific exceptions.)*

DES/DDD District Independent Oversight Committee (IOC) may have access to records upon request.

Health, safety and emergency personnel may have access as necessary to protect the health and/or safety of individuals.

All individual records should be maintained in an orderly, secure manner.

INDIVIDUAL'S RIGHTS TO CONSENT

The following three (3) conditions must be met for consent:

1. The person signing must have the necessary information to make an informed choice when giving consent.

2. The consent must be voluntary, without coercion involved.

3. A person, who may need assistance in making an informed choice in granting consent, shall be able to seek advice, counsel or assistance from significant others in making informed choices and decisions concerning consent, without coercion involved.

Explicit rights you have:

Implicit rights you have:

RIGHTS OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

Individuals with developmental disabilities have the same rights and privileges guaranteed to all citizens by the constitution and laws of the United States and the constitution and the laws of the State of Arizona.

A.R.S. 36-551.01 enumerates additional rights of those with developmental disabilities, including, but not limited to:

- Protection from physical, psychological, verbal or sexual abuse;
- Publicly supported educational services;
- Equal employment opportunities;
- Fair compensation for labor;
- Right to own, sell or lease property;
- Presumption of legal competency;
- Right to marry;
- Right to petition;
- Right to have placement evaluations;
- Right to a written plan of services and supports [Individual Support Plan (ISP) or Individualized Family Service Plan (IFSP);
- Right to notes documenting progress on the plan;
- Right to participate in the planning process and placement decisions;
- Right to be free from unnecessary and excessive medications;
- Individuals in residential programs have the right to a humane and clean physical environment, the right to communication and visits and the right to personal property;
- Individuals in residential programs have the right to live in the least restrictive alternative.
- Right to withdraw from services;
- Right to be informed of their rights upon admission to services.

ABUSE AND/OR NEGLECT

Abuse and/or neglect is prohibited in all services and programs operated or supported by DES/DDD and anyone so doing is subject to dismissal and prosecution. In addition, any person who mistreats an individual by any conduct, which is intimidating, degrading, or humiliating or who hits, kicks, pinches, slaps, pulls hair or improperly touches an individual shall be subject to dismissal and/or prosecution.

Abusive Treatment:

Abusive Treatment includes, but not limited to:

a. **Physical abuse** by inflicting pain or injury to an individual. This includes hitting, kicking, pinching, slapping, pulling hair or any sexual abuse (including inappropriate touch).

b. **Emotional abuse** which includes ridiculing or demeaning an individual, making derogatory remarks to an individual or cursing directed towards an individual.

c. **Programmatic abuse** is the use of procedures or techniques, which are not part of the support/service plan or are prohibited.

Neglect:

Neglect means a pattern of conduct without the person's informed consent resulting in deprivation of food, water, medication, medical services, shelter, cooling, heating, or other services necessary to maintain physical or mental health.

It also includes:

a. Intentional lack of attention to physical needs of the individual such as toileting, bathing, meals and safety.

b. Intentional failure to report medical problems or changes in health condition to immediate supervisor or nurse.

c. Sleeping on duty or abandoning work station (including leaving the individual unsupervised.)

d. Intentional failure to carry out a prescribed treatment plan for the individual.

If abuse or neglect of a DES/DDD eligible individual is suspected and/or observed, it must be reported immediately to the Division of Developmental Disabilities and Department of Child Safety (if the individual is under the age of 18) or Adult Protective Services (if the individual is 18 years or older), or law enforcement.

Abuse or Neglect

YOU

are a mandatory reporter!

Adult Protective Services:

1-877-SOS-ADULT

Department of Child Safety:

1-888-SOS-CHILD

POSITIVE TEACHING TECHNIQUES AND STRATEGIES
(Green Light Techniques)

Anyone can use the following positive teaching techniques and strategies. Paid caregivers (agency staff, individually contracted providers) will use the guidelines of the Individual's Plan (Individual Support Plan or Individualized Family Service Plan) in applying these techniques and strategies.

1. **Active Listening** is a technique used by those providing support to assure attention to and understanding of communication by the person they support. Methods can include stating what feelings are being expressed, repeating and/or paraphrasing what was said, asking questions to obtain the facts, and/or simply paying attention to and acknowledging the person assuring that the person's communications are attended to, understood and taken seriously. Focus is on the person communicating, not the person listening.
   ***Example**: Maria is playing a video game. Maria starts yelling and slaps the television screen. The support giver says, "Maria you seem mad." Maria replies, "Dumb game." The trainer says, "Is the game hard?" Maria says "Doesn't work." The trainer says, "The game doesn't work the way you want it to." Maria says, "Not fun." The support giver says, "You are not having fun with this game. What do you want to do?" Maria says, "Different game." The support giver says, "You want to play a different game. What game is fun for you?" Maria goes to the cabinet and gets a different game. Maria and the support giver change the games. Maria plays the new game and starts laughing.*

2. **Applied Behavior Analysis** is a group of techniques and strategies based upon the principles of analyzing behavior that have been demonstrated to be effective through use and research. These can include chaining, fading, shaping, prompting, discreet trial, etc. ***NOTE:** These techniques cannot involve the use of force without approval of the planning team, the Program Review Committee and review of the Independent Oversight Committee.
3. **Chaining** is a technique that breaks a task into smaller steps where each step acts as a prompt for the next step. Support giver assistance is faded from the steps of the task that the person masters first. Assistance can be faded from the first steps (forward chaining), the last steps (backward chaining) or middle steps (global chaining) of the task.

   ***Example**: Carlos is learning to brush his teeth, but he shows frustration trying to remember everything. The support giver breaks down the task into steps, such as picking up the toothbrush, wetting the brush, putting toothpaste on the brush, etc. The support giver*

begins by focusing on Carlos picking up the brush. When this is mastered, the focus changes to the next step.

4. **Cues/Prompts** are signals to engage in behavior. These signals can be those that naturally occur in the environment and those that are provided by support givers. The prompts provided by support givers can include gestures, visual cues, verbal instructions or information, auditory cues, physical guidance, tactile cues and rarely scent cues. These are also known as discriminative stimuli. (see also "Modeling")
   <u>Example</u>: *The meal has just finished. Jesse is learning to clean the table after dinner. The support giver prompts Jesse by handing him a cloth and asking him to clean the table.*

5. **Differential Reinforcement** is planned reinforcement of specific desirable behaviors, while not reinforcing other behaviors. Support givers actively encourage positive behavior using reinforcement and minimize reinforcement for undesired behavior.
   <u>Example</u>*: When Abdulah and Hakeem sit together and play a game quietly, their mother sits with them and plays the game. She tells them she enjoys being with them. Later when Abdulah and Hakeem are arguing over who has more marbles, their mom goes into the kitchen to do the dishes and does not talk to them.*

6. **Discrimination Training** is teaching a person to behave differently based upon the situation and environment.
   <u>Example</u>*: Don indiscriminately masturbates. Instead of trying to stop the behavior, Don is taught how to select an appropriate time and place such as a private time in his bathroom or bedroom.* ***And*** *Sam greets everyone with a hug, whether he knows them or not. Sam is taught to stop and ask himself the questions, "Do I know this person's first and last name?" "Do I see this person every day?" to help him identify if this person is a stranger and to change how he greets the person.*

7. **Environmental Manipulation** is also known as "environmental support", "environmental change" and "environmental engineering". This is creating environments that will make it more likely that the person will succeed. It can include setting up the environment to facilitate better learning, "avoiding" or "removing temptation", and elimination of environmental extremes and stressors (such as temperature, light, sound, contaminants, altitude, social groupings, etc.)
   <u>Example</u>*: Joe cries every time his mother prepares a meal making a stressful situation for both Joe and his mother. After some observation, it is determined that Joe's crying seems to happen when his mother leaves his sight. The living room sofa blocks Joe's view of his mother. The furniture is rearranged so Joe can see his mother. His crying stops and he is able to play in the living room while his mother prepares meals.* ***And***

Jaime and Jean sit across from each other at a table to do activities. Materials for activities lay on the table between them. They fight over the materials. The person supporting them sets up an additional activity area at another table. Jaime and Jean now have their individual materials at separate tables, and there is no fighting.

8. **Fading of Cues/Prompts** is a teaching technique that gradually reduces or withdraws the amount of assistance given to an individual. This involves actively assuring that "natural" environmental prompts are taught and gradually replace those provided by the support giver. (see also "Generalization Training" and "Graduated Guidance")
Example: *Guillermo is learning to get up in the morning and get out of bed. A support giver has been coming in and waking Guillermo up and telling him to get out of bed. An alarm clock is purchased and set to ring in the mornings. The support giver comes in and tells Guillermo that the alarm clock going off means it is time to get up. As time goes on the support giver talks less and lets the alarm clock ring longer. Finally the support giver stops going in to awaken Guillermo and Guillermo gets up when the alarm clock goes off.*

9. **Generalization Training** is a strategy or series of strategies to teach the person to display the behavior in all circumstances or situations where the behavior would normally or naturally occur.
Example*:* *Sally cannot tell the difference between the men's restroom and the women's restroom. Support givers teach her all of the symbols and words to be able to tell the difference in all situations.* ***And*** *Joshua is taught to zip his pants immediately every time that he puts them on and/or pulls them up regardless of where he is. In this way, Joshua always has his pants appropriately zipped in every circumstance.*

10. **Graduated Guidance** is a teaching technique that starts with the guidance necessary to support or assist the person in completing a task and gradually provides less assistance as the person gains or demonstrates greater competence. This usually refers to the use of physical assistance.
Example*:* *Taylor is learning to scoop food with a spoon. After the support giver has handed the spoon to Taylor and told Taylor to pick up the spoon, Taylor has still not responded. The support giver then physically guides Taylor's hand to the spoon. When Taylor's hand touches the spoon her fingers close around the spoon and she starts to lift the spoon. The support giver withdraws her hand from Taylor and allows Taylor to complete the motion*.

11. **Incidental Teaching** involves using the "teachable moment". Those who support individuals use normally occurring situations as well as random and unplanned occurrences to provide "on the spot" learning opportunities

to individuals. Sometimes this is "learner lead" with the support giver expanding upon the individual's lead or interest.
***Example**: While Tyler and a support giver are traveling to the ice cream shop, the vehicle they are in gets a flat tire. The support giver uses this as an opportunity to teach about getting safely off of the road, staying calm in a crisis and using tools to change the tire.*

12. **Modeling** is demonstrating the desired behavior to be imitated. (see also "Cues/Prompts")
    ***Example**: Alma is learning to fold clothes. The person supporting Alma sits next to her and also folds clothes or folds clothes while Alma watches.*

13. **Redirection** is a technique where the person is instructed to a different area, activity, choice or focus in order to interrupt the current behavior, **and** then problem solving to address the reason for the behavior, and/or training the acceptable replacement behavior follows. This technique is best used when a functional alternative behavior has been identified. Simply changing locations, circumstances, or attention may not address the underlying cause of the behavior. It may continue in the different situation or happen again after a short delay.
    ***Example**: Alberto is getting tired of feeding the birds on the back porch. He throws down the bag of seeds. The support giver noticed that prior to this Alberto was looking at the swing, the back gate and the door to the house. The support giver starts a conversation with Alberto. The support giver asks if he would like to sit down on the swing, go for a walk or go back in the house. Alberto goes to the swing, sits on it and begins to swing.*

14. **Reinforcement** is any event/item that immediately follows a behavior which increases the likelihood of the behavior occurring again. Reinforcing events/items can include a wide variety of objects, activities, interactions, occurrences or tokens/symbols.
    ***Example**: Han takes his plate to the kitchen and washes it. The support giver smiles and tells Han, "Thank you for washing your plate. Good job." (It is important to be specific about what is being praised.) In the future, Han repeats the behavior more frequently.*

15. **Relaxation Training** can involve a number of different strategies to help a person remain calm or use self-calming techniques in situations that otherwise produce stress and anxiety. Training can include biofeedback, desensitization, breath control, guided imagery, orderly muscle tension and relaxation, meditation, scripted "self-talk", etc.
    ***Example**: Dina becomes very anxious when she sees and/or hears thunderstorms. Dina is taught to close her eyes and take 3 slow deep breaths whenever she is aware of a thunderstorm.*

16. **Shaping** is a procedure during which support givers reinforce in a planned sequence closer and closer steps to learning a skill. At first the support giver would reinforce any response that even resembles the desired behavior. After that response is occurring with regularity, the support giver requires that the response be a little closer to the desired behavior before providing reinforcement. This continues until the individual is then displaying the desired behavior.
    <u>Example</u>: *André is expected to sit with his classmates at story time. Currently André wanders around the room. Whenever André comes within 3 feet of his chair the teacher praises André. Soon André starts hovering around his chair; then the teacher only praises André when he actually touches his chair. André starts touching his chair all the time, then the teacher only praises André when his leg touches the chair. Eventually André will sit in his chair in order to have the teacher praise him.*

17. **Token Economies** can be used with anyone as long as they do not require a person to earn basic necessities such as clothing, food and shelter and/or things that already belong to them, including money. Token economies are reward systems where tokens (symbols) are given for positive behavior, saved and exchanged for items of larger value. Token symbols can be poker chips, stars on a chart, stickers, checks on a calendar, or any other symbolic item.
    <u>Example</u>: *Jasmin really likes music CDs, however rewarding Jasmin with a music CD every day that she completes all of her house chores is not realistic or practical. A system is set up for her to accumulate tokens (stars on a calendar) and when she has twenty tokens she will get a new music CD (that is* ***not*** *purchased with her money).*

18. **Voluntary Time Out** is a procedure where the individual chooses to go to an area away from others to allow time and space to deal with stressors in the environment or feelings that can lead to difficult behavior. Those supporting the individual can suggest and/or encourage the individual to use time out, but the individual ultimately chooses whether s/he separates him/herself and for how long that will be.
    <u>Example</u>: *Simone comes home from day activities and starts yelling at those supporting her at home. One of the persons at her home suggests that she go to her room and relax for a few minutes. Simone goes to her room, lies on her bed for a few minutes and then comes back into the living room and calmly talks to others.*

BEHAVIOR PLAN

1. When does an individual need a behavior plan?

a. The team **must** write a plan:
for anyone prescribed a behavior modifying medication (except if living in their own or family home); or upon team decision to use any technique that requires approval, which includes any of the following:
-techniques that require the use of force,
-programs involving the use of response cost,
-programs which might infringe upon the rights of the individual
-protective devices used to prevent self-injury.

b. The team **may consider** developing a plan when the individual is displaying an inappropriate behavior that interferes with the individual's learning or participation in his/her community or places the individual or others at risk of harm.

c. The team **must meet and consider** writing a behavior plan when an emergency measure is used two or more times in a 30 day period or with any identifiable pattern.

2. If a behavior plan needs to be developed:

a. Describe the target behavior (inappropriate/interfering behavior) in specific terms – label and define.

b. Collect baseline data:
-Who, what, when, how often.
-Antecedents (what happened before the target behavior).
-Precursors (what is the person doing before the target behavior)
-Describe what the Target Behavior looks like.
-Consequences (what happens after the target behavior).

c. Examine the individual's environment to determine any issues that may be contributing to the inappropriate behaviors. This may include but not be limited to looking at: space, privacy, health, communication skills, relationships, and ability to make choices.

d. Look for the purpose/meaning/function of the target behavior – "why" is the individual displaying this behavior.

e. Determine the Alternative Behavior that will replace (or be incompatible with) the target behavior and how that alternative behavior will be taught:
-Write an alternative outcome to be taught.
-List the strategy to teach the alternative outcome.
-Include the reinforcement schedule.
-How will data be collected (mini-strategy for each antecedent behavior noted?
-What will be done if the target behavior occurs?
-List the name and/or title of the person who will train the staff who will be implementing the behavior plan and the name and/or title of the person who will monitor the implementation of the behavior plan on-site twice a month.
-The responsible person's signature and approval must be attained prior to implementation and review of the plan by the Program Review Committee.

3. Once the team writes a behavior plan and agrees to it:

The team needs to submit it for approval to the Program Review Committee and to the Independent Oversight Committee for review.

TECHNIQUES/PROGRAMS REQUIRING PRIOR REVIEW AND APPROVAL BY THE PROGRAM REVIEW COMMITTEE (PRC)
(Yellow light techniques)

R6-6-903. Program Review Committee

The ISP team shall submit to the PRC and Independent Oversight Committee for review any behavior plan, which includes:

1. **Techniques that require the use of force:**

    a. Forced Compliance
    b. Forced Exclusion Time Out
    c. The use of contingent observation, if force is required.
    d. Logical consequences, if force is used.

2. **Techniques that might infringe upon the rights of the individual:**

    a. Exclusion from activities within the daily routine.
    b. Restitution – Payment for repairs/replacement for property damage, etc.
    c. Reinforcement procedures that require the individual to earn basic necessities or personal possessions.
    d. Giving up a reinforcement tool that has already been earned as a consequence to a behavior that occurred after earning the reinforcement tool.
    e. Limitations, some examples are:
        - cigarettes
        - access to the community
        - soda or coffee
        - phone privileges, if individual uses phone excessively
        - access to food and basic necessities

3. The use of behavior modifying medications as ordered by a physician, as part of the treatment strategy to address/manage behavioral issues:
NOTE: This does not apply when an individual is living in his/her own home or family home.

a. Prior review by PRC is not required for situations where the prescribing physician orders behavior-modifying medications to accomplish a specific "one time" medical or dental procedure.

b. The planning team must convene and initiate development of a plan within 30 days of the start of behavior modifying medications.

c. Within 90 days, the planning team should have the plan completed and forwarded to the Program Review Committee for review.

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4. Protective devices used to prevent an individual from sustaining injury as a result of his/her self-injurious behavior:

a. Protective devices that are utilized to prevent and/or minimize injury from incidents of self-abusive behavior, such as helmets, arm wraps, splints, etc.

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TRAINING REQUIREMENTS FOR PEOPLE IMPLEMENTING BEHAVIOR PLANS

R6-9-906. Training

Any person who is involved in the use of a behavior plan shall be trained by the Division or trained by an instructor approved by the Division prior to such involvement.

A. Initial training shall cover at a minimum:

1. **Provisions of law related to:**

   a. **Interventions, particularly this Article and 42 CFR 483.450 (October 1, 1992)**
   b. **Rights of individuals with developmental disabilities**
   c. **Confidentiality**
   d. **Abuse and neglect**

2. **Intervention techniques, treatment and services, particularly addressing the risks and side effects that may adversely affect the individual.**

3. **The development, implementation and monitoring of a person specific behavior plans.**

4. **A general orientation to:**

   a. **Division goals with respect to the provision of services to individuals with developmental disabilities.**
   b. **Related policies and instructions of the Division.**

B. With respect to the use of techniques, the Rule indicates training shall include hands-on or practical experience conducted by instructors approved by the Division, and who have experience in the actual use of the interventions as opposed to administrative responsibility for such use. The Rule also indicates "physical management techniques shall only be used by those persons specifically trained in their use".
The Rule, and associated Department of Economic Security, Division of Developmental Disabilities policies and procedures, licensing and/or certification requirements indicate that:
Any person providing direct services to individuals who have the potential to exhibit inappropriate behaviors, which may require physical management and control, receive training in the use of interventions. The

intervention training should include hands-on or practical experience conducted by an instructor approved by the Division, using a curriculum approved by the Division, and who have experience in the actual use of interventions as opposed to administrative responsibility for such use.

Currently, the intervention training recognized to meet this training requirement is the Division's "Prevention and Support". All other forms of physical intervention training must be reviewed and approved by the Division to ensure compliance with this rule, the associated policies and procedures of the Division.

All persons using emergency physical intervention techniques shall:

a. Have successfully completed a course in the use of those emergency physical intervention techniques.
b. Receive instruction in emergency physical intervention techniques only from an instructor certified and/or approved by Department.
c. Be re-certified in emergency physical intervention techniques periodically as determined by the Division of Developmental Disabilities or determined by their supervisor.

C. Any person providing direct service to an individual whose program involves the utilization of behavior modifying medications shall receive training that includes:

1. An overview of drug use, interactions and contraindications;

2. A discussion of planned reductions in the use of such medications and clinical rationale for continued use;

3. Identification of side effects of the use of behavior modifying medications including, but not limited to, Tardive Dyskinesia; and

4. Instruction in methods for reporting results of medication use.

D. The Division shall provide all persons serving on a Program Review Committee (PRC) and Independent Oversight Committee (IOC), training and information relative to the Division and Department rules and procedures, and contemporary practices in behavior treatment.

E. In addition to initial training, the Division shall ensure that training is available as necessary to maintain currency in knowledge and recent technical trends related to intervention trends related to intervention for the management of inappropriate behaviors.

PROHIBITED TECHNIQUES
(Red light techniques)

R6-6-902. Prohibitions

The following behavioral intervention techniques are prohibited:

1. **The use of seclusion (locked time out) rooms.**

   Defined as placing an individual in a room and locking or holding the door shut, thus preventing egress. (Includes the use of **force** to place or maintain an individual in a **confined** area, **alone** and/or **without interaction**.)

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2. **The use of overcorrection.**

   Defined as a group of procedures used as a consequence to an individual's behavior, which involve either:

   a. requiring an individual to restore an environment to a state vastly improved from that which existed prior to the behavior, or
   b. requiring an individual to repeatedly practice a behavior.

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3. **The application of noxious stimuli.**

   Defined as the utilization of a stimulus that is considered to be highly unpleasant to the individual, including, but not limited to:

   a. Offensive tastes
   b. Loud, high-pitched, or otherwise unpleasant noises
   c. Offensive odors
   d. Offensive tactile stimuli
   e. Offensive visual stimuli

4. **Physical restraints, including mechanical restraints, when used as a negative consequence to a behavior.**

    a. Physical restraints are defined as, but not limited to, full body restraints, basket weave/standing restraints, and seated restraint procedures.
    b. Mechanical restraints are defined as a device utilized to limit "freedom of movement".

    Notes:

    1. *The Rule prohibits the use of physical restraints, except in the case of an emergency (See R6-6-908. Emergency Measures). The utilization of physical restraint procedures is prohibited when used as a consequence to a behavior.*
    2. *Restraint techniques/procedures **can** be utilized to achieve medical/dental care and treatment, as ordered by a physician.*
    3. *Any lying restraint (supine, prone or side) and any seated restraint where the person is placed on the floor or ground, arms are crossed in front of them and pressure is applied to fold or press their body forward are prohibited.*

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5. **The use of behavior modifying medication, except as specified in R6-6-909, if:**

    a. They are administered on an "as needed" or "PRN" basis; or

    1. PRN – An abbreviation indicating "as needed".
    2. The decision to administer and/or increase the dosage of the behavior modifying medication is based on the paid provider's discretion.

    b. They are in dosages which interfere with the individual's daily living activities; or

    c. They are used in the absence of a behavior plan.

    1. See R6-6-909.B.2–states behavior modifying medications shall be prescribed and administered only as part of a behavior plan in the annual plan (ISP, IFSP).

<u>Note:</u> Except where there is an "exemption" established by the Division.

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6. Those addressed in A.R.S. Section 36-561.A.

A.R.S. Section 36-561.A. states "No psycho surgery, insulin shock treatment or electroshock or experimental drugs shall be administered by the Department to any individual, nor shall the Department license, approve, support any program or service which uses such treatments of drugs."

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Individual Support Plan Team

Responsibilities:

1. The planning team must submit to the PRC and IOC committees any behavior plan which includes:
   a. techniques that require the use of force;
   b. programs involving the use of response cost; this means a procedure often associated with token economies, designed to decrease inappropriate behaviors, in which reinforcement tools, already earned, are taken away or not awarded as a consequence of inappropriate behavior;
   c. programs which might infringe upon the rights of the individuals;
   d. the use of behavior modifying medications; and
   e. protective devices used to prevent an individual from being injured due to self-injurious behavior.
2. Upon receipt of the response from the PRC, and as part of the plan development process, the planning team must either:
   a. implement the approved behavior plan;
   b. accept the PRC recommendation, and incorporate the revised behavior plan into the plan (ISP or IFSP) or
   c. reject the PRC recommendation and develop a new behavior plan.
3. All revised behavior plans must be re-submitted to the PRC for approval and the IOC for review and recommendation.

No implementation shall occur prior to approval.

Monitoring Behavior Plans:

Each planning team shall specifically designate and record in the plan (ISP/ IFSP) the name of a member of the team, excluding those direct service staff responsible for implementing the approved behavior plan, who shall:

a. Ensure that the behavior plan is implemented as approved.

b. Ensure that all persons implementing the behavior plan have received appropriate training as specified in R6-6-906.

c. Ensure that accurate data on the learning objective and the target behavior(s) are maintained in the individual's record.

d. Evaluate, at least monthly, collected data and other relevant information as a measure of the effectiveness of the behavior plan.

e. Conduct on-site observations not less than twice per month and prepare, sign, and place in the individual's record a report of all observations.

(Taken from A.A.C R6-6-903a, 904 and 905.)

DISTINGUISHING BETWEEN THE PRC AND THE IOC COMMITTEES

<table>
<tr><th>Program Review Committee (PRC)</th><th>Independent Oversight Committee (IOC)</th></tr>
<tr><td>PRC means a specially constituted committee that meets the requirements of 42 CFR section 483.440 (f) (3) and Article 9.</td><td>IOC means a committee established by the department whose members are appointed by the director from a list of candidates recruited in the local area that meet the requirements of ARS 41-3801.</td></tr>
<tr><td>The PRC shall be comprised of at least the following:
□ A representative of the DDD who shall act as the chairperson as designated by DPM
□ A person who provides habilitation services
□ A person qualified as determined by the Division in the use of behavioral techniques
□ A parent of a person with a developmental disability, whose child’s program is not being reviewed
□ A lay person
□ A person with a developmental disability</td><td>The I0C shall consist of no less than seven, nor more than fifteen persons with expertise in one or more of the following areas:
□ Psychology
□ Law
□ Medicine
□ Education
□ Parent and/or a person with a developmental disability</td></tr>
<tr><th>Responsibilities of PRC:</th><th>Responsibilities of I0C:</th></tr>
<tr><td rowspan="3">Approve or disapprove all individual plans that include:
1. Techniques which use force
2. Programs involving the use of response costs
3. The use of behavior modifying medications
4. Programs which infringe on the rights of individuals
5. The use of protective devices relative to an individual’s self-injurious behavior</td><td>Provide independent oversight and review with regard to:
1. All aversive or intrusive behavior plans
2. The use of behavior modifying medications
3. Research affecting individuals
4. Possible instances of abuse, neglect, or denial of individual rights</td></tr>
<tr><td>Forward to the District Program Manager written objections to actions by employees of the department or contract service providers.</td></tr>
<tr><td>No employees of the department or contract service provider may be a voting member of an IOC or otherwise direct committee decision-making.</td></tr>
</table>

REPORTING EMERGENCY MEASURES

1. Emergency Measures:

Definition of an "Emergency Measure" in the event that an individual engages in a sudden, intense, out of control behavior endangering the health or safety of the individual or another person, the use of emergency physical intervention techniques and/or behavior modifying medication with a physician's order for specific one time emergency use.

Note: Emergency measures described here are not to be confused with the prohibited technique of physical restraints, including mechanical restraints, when used as a negative consequence to a behavior as listed in R6-6-902.A.4.

The team must meet and consider writing a behavior plan when an emergency measure is used two or more times in a 30 day period or any identifiable pattern.

2. Emergency Physical Management Techniques:

When the behavior plan techniques are ineffective, staff shall use the least amount of intervention necessary to safely physically manage the individual's out-of-control behavior. These techniques are included in Prevention and Support and shall be:

- used only by individuals specifically trained in the use of Emergency Physical Intervention Techniques
- used only when less restrictive methods were unsuccessful or inappropriate
- used to prevent the individual from harming him or herself or others or causing damage to property that would result in harm to him or herself or others
- continued for the least amount of time necessary to bring the individual's behavior under control
- be used concurrently with the uncontrolled behavior
- be appropriate to the situation to insure safety

3. Reporting Procedures:

When a physical management technique is employed to manage a sudden, intense behavior, the person employing that measure shall:

a. Immediately (*The Division interprets "immediately", as the first allowable opportunity that does not place the individual or staff at undue risk, as applicable to the situation, and not to exceed 24 hours*) report the circumstances of the emergency measure to the following:
   1. The person designated by the Division
   2. The responsible person

b. After calling the above individuals, a full and complete written report of the circumstances of the emergency measures needs to be submitted within one working day to the support coordinator and the district central reporting site.

SANCTIONS

R6-6-907. Sanctions

For programs operated, licensed, certified, supervised or financially supported by the Division, failure to comply with any part of this Article may be grounds for suspension or revocation of a license, for termination of contract, employment, or applicable administrative or judicial remedy.

This portion of the Rule establishes the Division's authority to require compliance with Article 9 for all programs operated, licensed, certified, supervised or financially supported by the Department of Economic Security, Division of Developmental Disabilities.

Failure to comply with:

1. any part of the Rule and associated Division Policies and Procedures,
2. to satisfactorily complete training required by Rule before engaging in behavior treatment interventions,
3. or to make timely oral or written reports as designated may result in suspension or revocation of a license or other forms of Departmental approval, termination of contract or employment, or any other applicable administrative or judicial remedy as prescribed by law.

ARTICLE 9 MANAGING INAPPROPRIATE BEHAVIORS

R6-6-901. Applicability

These rules apply to:

- 1. All programs operated, licensed, certified, supervised or financially supported by the Division.
- 2. All habilitation programs as defined in A.R.S. § 36-551(18), as well as all interventions included in this Article, shall be addressed in the individual's ISP.

R6-6-902. Prohibitions

A. The following behavioral intervention techniques are prohibited:
  1. The use of seclusion (locked time-out rooms).
  2. The use of overcorrection.
  3. The application of noxious stimuli.
  4. Physical restraints, including mechanical restraints, when used as a negative consequence to a behavior.

B. The use of behavior modifying medications is prohibited, except as specified in R6-6-909, if:
  1. They are administered on an "as needed" or "PRN" basis; or
  2. They are in dosages which interfere with the client's daily living activities; or
  3. They are used in the absence of a behavior plan.

C. No person shall implement a behavior plan which:
  1. Is not included as a part of the ISP; and
  2. Falls under R6-6-903(A), without approval of the PRC.

R6-6-903. Program Review Committee (PRC)

A. The ISP team shall submit to the PRC and Independent Oversight Committee any behavior plan which includes:
  1. Techniques that require the use of force.
  2. Programs involving the use of response cost.
  3. Programs which might infringe upon the rights of the client pursuant to applicable federal and state laws, including A.R.S. § 36-551.01.
  4. The use of behavior-modifying medications.
  5. Protective devices used to prevent a client from sustaining injury as a result of the client's self-injurious behavior.

B. The PRC shall be responsible for approving or disapproving plans specified in subsection (A) above and any other matters referred by an ISP team member.

C. The PRC shall review and respond in writing within ten working days of receipt of a behavior plan from the ISP team, either approving or disapproving the plan. The response shall be signed and dated by each member present and shall be transmitted to the ISP team with a copy to the chairperson of the Independent Oversight Committee for review and recommendations at its next regularly scheduled meeting pursuant to R6-6-1701 et seq. The response shall include:
  1. A statement of agreement that the interventions approved are the least intrusive and present the least restrictive alternative.
  2. Any special considerations or concerns including any specific monitoring instructions.

3. Any recommendations for change, including an explanation of the recommendations.

D. Each PRC shall issue written reports, as prescribed by the Division, summarizing its activities, findings and recommendations while maintaining client confidentiality.
   1. On a monthly basis, report to a designated Division representative, with a copy to the chairperson of the Independent Oversight Committee.
   2. On an annual basis, by December 31 of each calendar year, report to the Assistant Director of the Division of Developmental Disabilities, with a copy to the Developmental Disabilities Advisory Council.

E. The PRC shall be composed of, but not be limited to, the following persons designated by the District Program Manager:
   1. The District Program Manager or his designee, who shall act as a chairperson.
   2. A person directly providing habilitation services to clients.
   3. A person qualified, as determined by the Division, in the use of behavior management techniques, such as a psychologist or psychiatrist.
   4. A parent of an individual with a developmental disability but not the parent of the individual whose program is being reviewed.
   5. A person with no ownership in a facility and who is not involved with providing services to individuals with developmental disabilities.
   6. An individual with a developmental disability when appropriate.

F. A PRC shall be separate from but a complement to the ISP team, and the Independent Oversight Committee established pursuant to R6-6-1701 et seq.

R6-6-904. ISP Team Responsibilities

Upon receipt of the PRC's response and as part of its development of the client's ISP, the ISP team shall either:

1. Implement the approved behavior plan; or
2. Accept the PRC recommendation and incorporate the revised behavior plan into the ISP; or
3. Reject the recommendation in whole or in part and develop a new behavior treatment plan to be resubmitted to the PRC and Independent Oversight Committee.

R6-6-905. Monitoring Behavior Plans

Each ISP team shall specifically designate and record in the ISP the name of a member of the team, excluding those direct service staff responsible for implementing the approved behavior plan, who shall:

1. Ensure that the behavior plan is implemented as approved.
2. Ensure that all persons implementing the behavior plan have received appropriate training as specified in R6-6-906.
3. Ensure that objective, accurate data are maintained in the client's record.
4. Evaluate, at least monthly, collected data and other relevant information as a measure of the effectiveness of the behavior plan.
5. Conduct on-site observations not less than twice per month and prepare, sign, and place in the client's record a report of all observations.

R6-6-906. Training

A. Any person who is involved in the use of a behavior plan shall be trained by the Division or trained by an instructor approved by the Division prior to such involvement.

B. Initial training shall cover at a minimum:

1. Provisions of law related to:
   - c. Interventions; particularly this Article and 42 CFR 483.450 (October 1, 1992), incorporated herein by reference and on file with the Office of the Secretary of State;
   - d. Legally mandated rights of individuals with developmental disabilities; particularly A.R.S. §§ 36-551.01, 36-561 and 42 CFR 483.420 (October 1, 1992), incorporated herein by reference and on file with the Office of the Secretary of State;
   - e. Confidentiality; particularly A.R.S. §§ 41-1959 and 36-586.01 and 42 CFR 483.410(c)(2) (October 1, 1992), incorporated herein by reference and on file with the Office of the Secretary of State.
   - f. Abuse and neglect prohibitions pursuant to A.R.S. § 36-569.
2. Intervention techniques, treatment and services, particularly addressing the risks and side effects that may adversely affect clients.
3. A general orientation to:
   - a. Division goals with respect to the provision of services to people with developmental disabilities.
   - b. Related policies and instructions of the Division.

D. With respect to the use of interventions, training shall include hands-on or practical experience to be conducted by instructors approved by the Division, using a curriculum approved by the Division, and who have experience in the actual use of interventions as opposed to administrative responsibility for such use.

E. In addition to initial training, the Division shall ensure that refresher training is available as necessary to maintain currency in knowledge and recent technical trends related to intervention for the management of inappropriate behavior.

F. Physical management techniques shall only be used by those persons specifically trained in their use.

G. The following records and documents related to training shall be maintained by the Division for five years and be available for public inspection.

1. A summary of the training plan adopted by the Division in compliance with this Section, including schedules, instructors, topics, and expressed parameters of the hands-on or practical experience component of the training.
2. Required special knowledge, skills, training, education or experience of the instructors related to managing inappropriate behaviors.
3. A list of persons satisfactorily completing initial and refresher courses and course dates.

H. The Division shall review the training plan at least every two years for compliance with all applicable provisions of law and Division policy as well as for the protection of clients.

R6-6-907. Sanctions

For programs operated, licensed, certified, supervised or financially supported by the Division, failure to comply with any part of this Article may be grounds for suspension or revocation of a license, for termination of contract, employment, or for any other applicable administrative or judicial remedy.

R6-6-908. Emergency Measures

A. Physical management techniques employed in an emergency to manage a sudden, intense, or out-of-control behavior shall:
   1. Use the least amount of intervention necessary to safely physically manage an individual.
   2. Be used only when less restrictive methods were unsuccessful or are inappropriate.
   3. Be used only when necessary to prevent the individual from harming self or others or causing severe damage to property.
   4. Be used concurrently with the uncontrolled behavior.
   5. Be continued for the least amount of time necessary to bring the individual's behavior under control.
   6. Be appropriate to the situation to insure safety.

B. When an emergency measure, including the use of behavior modifying medications pursuant to R6-6-909(D), is employed to manage a sudden, intense, out-of-control behavior, the person employing that measure shall:
   1. Immediately report the circumstances of the emergency measure to the person designated by the Division and to the responsible person.
   2. Provide, within one working day, a complete written report of the circumstances of the emergency measure to the responsible person, the case manager, the chairperson of the Program Review Committee, and the Independent Oversight Committee.
   3. Request that the case managers reconvene the ISP team to determine the need for a new or revised behavior plan when any emergency measure is used two or more times in a 30-day period or with any identifiable pattern.

C. Upon receipt of a written report as specified in paragraph (B)(2) above, the PRC shall:
   1. Review, evaluate and track reports of emergency measures taken; and
   2. Report, to a person designated by the Division, instances of possible excessive or inappropriate use of emergency measures on a case-by-case basis for corrective action.

R6-6-909. Behavior-modifying Medications

A. The Division shall make available the services of a consulting psychiatrist who shall review cases and provide recommendations to prescribing physicians to ensure that the medication prescribed is the most appropriate in type and dosage to meet the client's needs.

B. Behavior-modifying medications shall be prescribed and administered only:
   1. When, in the opinion of a licensed physician, they will be effective in producing an increase in appropriate behaviors; and it can be justified that the harmful effects of the behavior clearly outweigh the potential negative effects of the behavior modifying medication.

2. As part of a behavior treatment plan in the ISP.
3. With the informed consent of the responsible person.

C. The Division shall provide the following monitoring, in addition to that specified in R6-6-905, for all behavior plans that include the use of a behavior-modifying medication:
1. Ensure that collected data relative to the client's response to the medication is evaluated, at least quarterly, at a medication review by the physician and the member of the ISP team designated pursuant to R6-6-905 and other members of the ISP team as needed.
2. Ensure that each client receiving a behavior-modifying medication is screened for side effects, and Tardive Dyskinesia as needed, and that the results of such screening are:
   a. Documented in the client's case record;
   b. Provided immediately to the physician, responsible person, and ISP team for appropriate action if the screening results are positive; and
   c. Provided to the Program Review Committee and the Independent Oversight Committee within 15 working days for review of screening results that are positive.

D. In the event of an emergency, a physician's order for a behavior modifying medication may, if appropriate, be requested for a specific one-time emergency use. The person administering the medication shall immediately report it pursuant to R6-6-908(B).

E. The responsible person shall immediately be notified of any changes in medication type or dosage