Crisis Intervention

A guide to assist Direct Support Professionals when responding to an emergency situation that places the individual or others at risk of physical harm

Outcomes:

Direct Support Professional will understand what emergency physical intervention is and when it can be used.

Direct Support Professional will understand the principle of least restrictive to most restrictive.

Direct Support Professional will understand what must be documented when emergency physical intervention is used. Direct Support Professional will understand when it is inappropriate to use emergency physical intervention.

CRISIS INTERVENTION TRAINING CHECKLIST

Trainer must have received training in the emergency physical intervention techniques and demonstrated ability to perform the techniques prior to teaching DSP staff.

- 1. Have the Direct Support Professional (DSP) read the unit.
- 2. Demonstrate the techniques and have the DSP practice each technique.
- 3. Trainer will complete the "Emergency Physical Intervention Skill Demonstrations" form.
- 4. Trainer will review the AFC administrative rules 400.14309 [400.15309] -Crisis intervention with the DSP and answer any questions. The trainer should assure the DSP knows where the AFC licensing rules are located in the home for easy reference.

Crisis Intervention

Crisis intervention procedures may be used <u>only</u> when an individual has not shown this behavior in the past which is now creating the crisis situation or there has not been enough time to develop a specialized intervention plan to reduce the behavior causing the crisis. This would be considered an "emergency" situation.

The previous unit: Positive Approaches to Challenging Behaviors – Non Aversive Techniques should always be reinforced and be considered the primary focus on learning to work with individuals who display challenging behaviors. The more the Direct Support Professional understands the concepts taught in Unit 10 the less chance that "Crisis Intervention" will happen at all.

If the individual requires repeated or prolonged use of crisis intervention procedures the licensee needs to contact the individuals designated representative as stated in their person centered plan along with the responsible agency. If there is not a responsible agency in place such as a Community Mental Health Board, a "licensed professional" who is certified and knowledgeable should assist the licensee with making appropriate recommendations which would involve a review process to evaluate positive alternatives or the need for a specialized intervention plan.

Crisis Intervention may be used for the following reasons:

- To provide for self-defense or the defense of others
- To prevent an individual from causing self harm
- To stop a disturbance that threatens physical injury to any person
- To obtain possession of a weapon or any dangerous object that is in possession of the individual causing the crisis
- To prevent "serious" property destruction

Crisis Intervention will only be used with as little control as necessary and only for as little amount of time needed to help the person regain their self-control. The crisis intervention should only be used after other less restrictive methods have been tried and failed.

Crisis Intervention techniques should be used with minimum discomfort to the person both physically and mentally. This should allow for the greatest possible comfort and avoid physical injury and mental distress.

Crisis Intervention should never be used as a regular routine!

Any time a crisis intervention method/technique is used it must be documented in the individual's record and on an incident report. The documentation should include the following:

- The type of crisis intervention that was used (with as many details on the actual incident as possible...be descriptive!)
- How long (amount of time) the intervention took to implement from beginning to end

- The "reasons" why the intervention was used. Have good justification for your decision to use the crisis intervention.
- Be specific and list all the less restrictive alternatives that were tried, how long they were tried, how many times, and what kind of results were received by trying to use them.
- Always include all names of the direct support professionals who were involved in the crisis incident and the actions they took. Include the name of the person who <u>authorized the use</u> of the crisis intervention.
- Be sure to include the times and date that the crisis intervention was used and the name of the DSP who implemented the crisis intervention.

A licensee shall make available reports of all uses of crisis intervention when requested by the individual or their designated representative, the responsible agency or the Department of Community Health. There should be reporting guidelines in place from your designated agency (Community Mental Health for Central Michigan) that you are required to follow when these types of incidents occur.

A licensee or Direct Support Professional are not allowed to use the specific crisis intervention techniques described in this unit without proper training. Training must be approved by the responsible agency which will receive approval from the Department of Community Health.

The Crisis Intervention techniques described in this unit are the techniques approved and trained by Community Mental Health for Central Michigan. The Techniques to Protect Yourself and Others and Techniques Used to Assist With Regaining Self Control are only to be taught by "certified trainers" who have approval to teach these techniques from Community Mental Health for Central Michigan. There should be documentation in place to verify the Trainer is certified by Community Mental Health for Central Michigan.

Things to know about crisis intervention & emergency physical intervention techniques

The Four A's: Decision Steps for Intervening are outlined below if an individual is becoming agitated the DSP should think and plan for the intervention using these steps.

Awareness

- Physical environment
- Your emotional state
- > Other people and staff present
- Outside resources available

Assess/Analyze

- What does the situation mean?
- Does the person need something?

- What should happen?
- > Do I need to do anything?

Anticipate

- What is the person likely to do next?
- What is likely to happen if I do something?
- ➤ What is likely to happen if I do nothing?

Act

- Make a conscious choice to intervene
- OR, make a conscious choice NOT to intervene

Cautions To Be Observed During Physical Intervention used in a crisis situation

WHEN TO STOP PHYSICAL INTERVENTION:

DSP staff performing physical intervention during a crisis situation should be alert for signs and symptoms of a problematic physical condition, especially in the presence of unusual behavior changes. These signs or symptoms may be, but are not limited to:

- Breathlessness, difficulty or cessation in breathing
- Severe coughing
- Significant change in skin color
- Vomiting
- Complaints of chest pain or pressure
- Bleeding from body orifice (other than a minor lip injury)
- Seizure activity
- Incontinence of bowel or bladder

DSP staff who know the individuals they work with should be aware of any unusual signs and symptoms exhibited during physical intervention.

IF PHYSICAL INTERVENTION HAS BEEN STOPPED DUE TO PHYSICAL DISTRESS:

- Immediately implement First Aid or CPR as indicated by the observed symptoms
- Contact 911/Emergency Medical System as necessary
- Notify on-call personnel

Points to Remember when using Physical Intervention:

- Remain Calm. Time is on your side
- Whenever possible, get other people out of the way. If this is not possible try
 to direct the action away from their view
- Don't use physical intervention alone, unless you have no alternative. Even having another DSP observing will provide support.

- Communicate! Keep people informed. Give directions to others if needed.
- Know individuals well "before" you get in a crisis situation with them
- After any crisis intervention, debrief with the person (if they are able) and others that were present about what happened.
- Defuse yourself...take time to unwind and get the right "mind set" before you document
- Always report and document the incident in as much detail as possible so everyone has a clear picture of what happened.

Inappropriate Uses of Physical Intervention:

- Using a physical intervention when other less restrictive techniques have not been tried first.
- To make individuals follow the rules, as a form of discipline, to threaten, to show who's boss, and to vent feelings of anger.
- Using physical intervention when you don't know the individual
- Using physical intervention when there is a great size and/or strength difference between you and the individual.
- Using physical intervention because you are embarrassed by the individual's behavior.
- When you know using physical intervention will only make the situation worse.
- Using Direct Support Professionals who have not been "trained" to assist! Everyone must be trained to work with crisis situations.
- When the individual has a weapon with the intent to cause harm.

Physical Intervention should ALWAYS be used as a last resort!!!

There are two categories of techniques which have been approved for use in an emergency: "Techniques to protect yourself and others" and "Techniques to transport and assist in regaining self control".

"Techniques to protect yourself and others" are defensive physical maneuvers to keep staff and others from being injured when someone becomes aggressive. They allow the person time to regain self-control. These interventions are always used in conjunction with other strategies, such as, Confrontation Avoidance Techniques (CAT) and proactive options. All of the techniques are based on the principles of body mechanics; balance, quickness, and protection of vulnerable body parts.

Blocks are defensive techniques that protect you from injury when people hit or throw things.

Blocks, the least restrictive techniques, must be used in conjunction with CAT and proactive option intervention strategies learned earlier to assist the individual in regaining self-control.

Keep the following principles in mind to effectively use blocks when interacting with an aggressive person:

• Stay one step ahead of the person.

- Remain alert and observant, so that aggressive moves can be anticipated.
- Do not corner the person or allow yourself to be cornered.
- Maintain your balance and protect vulnerable body parts. Body position and stance are critical. Maintain balance by keeping your feet slightly apart and your body and hands relaxed. Turn your body slightly to one side to protect your midsection.
- Your physical and emotional posture should convey a message of willingness to help the person regain self-control.
- Stay sensitive to the message conveyed by your stance and position.
- Open palms and relaxed hands and arms express openness and a willingness to listen and be helpful.

Techniques to transport and assist in regaining self control are an intrusion into the other person's "space." As a result, there are more cautions associated with their use:

- Intrusions into anyone's space limits their rights to free movement and choice.
- Techniques that physically control increase the risk of injury to staff and the person.
- The use of physical control as a response to behavior often has negative, unpredictable side-effects. It may take a way from a good relationship, or make worse an already poor relationship. It may force anger to be held in until a person explodes. It may decrease self-esteem. It may be humiliating, insulting, and dehumanizing. Transport techniques MUST always be used as a last resort. They may only be used when all other intervention strategies have been tried and have failed. Techniques must:
- Maintain the safety and dignity of staff and the person they are working with.
- Help the person regain and learn self-control.
- Minimize the potential for misuse, abuse, and injury.

What are "Transport Techniques?"

Transport techniques are physical maneuvers that allow the DSP to physically control the actions and movements of an individual who threatens to harm them self, others, or severe property destruction. They are used to keep a person in one spot, to move a person to a safer area, or control a person's actions by controlling body position and movement. They enable the DSP to protect themselves and others from the aggressive actions of an individual and allow the person to regain self-control. These are the most restrictive of all interventions and may be used only as a last resort in an emergency situation.

AFTER PHYSICAL INTERVENTION

1. DECOMPRESS

2. DEBRIEF

3. DOCUMENT

DECOMPRESS:

Take time as soon as possible after the use of physical intervention to "unwind" or decompress. When you have been in an intense situation, adrenaline flows.

Decompression means relieving pressure or to get things back to normal. You need to take some time to relieve the pressures created by the confrontation. If this is not done, the pressures or negative feelings may get worse until they interfere with your ability to

work effectively with that person and / or others who live and work in the licensed residential setting.

Before taking time to decompress make sure the confrontation is over. Has the person regained self-control? Has the environment returned to normal? The safety and well-being of the people living in the home is your first priority.

There are many ways to decompress. Learn what will work best for you. When choosing a decompressing activity, one that uses up physical energy works best. Some people decompress with a brisk, short walk. Others may sit and get some fresh air, do stretching or relaxation exercises, do some deep breathing, meditate, drink a glass of water, etc.

DEBRIEF:

Debriefing occurs when the DSP staff discuss and analyze information gathered during an incident. Because everyone sees things from a different angle and we want to avoid another incident, this is an important follow-up after using any physical intervention technique. Debriefing can also help staff decompress by sorting out thoughts and feelings about the incident. Other DSP staff can help you get a more complete and clear picture of what really happened. Discuss what happened before, during, and after the confrontation occurred. Plan for future interventions. If physical confrontations occur often, the individual's person centered planning team should meet to review the plan and possibly revise it to reflect what is happening with the individual.

Answer these questions during the debriefing:

- How did I feel before, during, and after the physical confrontation?
- What was the person doing before, during, and after the confrontation?
- What signs of agitation did I or others observe before the confrontation?
- What non-physical intervention techniques were used?
- What happened as a result?
- Was the physical intervention technique effective?
- Was the technique used the least restrictive one possible in the situation?
- Was the technique done correctly?
- Did other staff assist? If "no" why?
- If "yes" was communication clear between staff? Were actions coordinated?
- Were other people present? Were they removed from the area/made safe?
- If the incident happened again, what would I do?
- How will this affect interactions with this individual in the future?

Debrief with the person involved in the confrontation, if appropriate, after he or she has calmed down and re-established self-control.

DOCUMENT:

All physical injuries, unusual behavior, and physical intervention techniques must be documented on an Incident Report.

Documentation of agitated and aggressive behavior, as well as physical intervention techniques used provides important information. Documentation will tell if the individual is making .progress. Remember the DSP must be descriptive not evaluative when documenting. Write down what you see, not what you think those actions mean.

The following should be documented after the use of physical intervention:

- The date, time, and length of the incident.
- The specific location and the DSP staff and other people involved and/or present.
- What happened before, during, and after the intervention? Note the specific behaviors that occurred by everyone involved in the incident including other staff.
- The non-physical interventions used. Physical interventions are justified only when other interventions have failed, or in an emergency. If no other techniques were used state why this was an emergency.
- What physical intervention techniques were used? Name the specific techniques used.
- What was done following the physical intervention? If there were injuries, who, was the incident reported to? What was done to help the person calm down?
- If you debriefed with the person, what were his or her thoughts and feelings about what happened?

This information documented in the individual's record and be communicated to other DSP staff and the case manager.

The emergency physical intervention "Protective" techniques which have been approved for use

are: Blocks

Hands Down

One Person Come-A-Long (used to protect someone from falling during ambulation)

The emergency physical intervention "Transporting & Assisting in Regaining Self Control" techniques which have been approved for use are:

Come-A-Longs- One person and Two person

Wrap Arounds- Front wrap around and wrap around from behind

You will receive training in the emergency physical intervention techniques from a "Qualified" trainer. Frequent practice of the techniques, effective communication and coordination with other DSP staff will help you to implement these techniques safely in an emergency situation.

Remember, the goal is to diffuse the situation and not have to implement emergency physical intervention. If you develop good relationships with the individuals you support you may never need to use emergency physical intervention.

- I. PURPOSE: To establish policies and procedures which guide the application and oversight of behavior treatment.
- II. APPLICATION: Programs operated by or under contract or agreement with Community Mental Health for Central Michigan.

III. REFERENCE:

- A. Michigan Mental Health Code
- B. Michigan Department of Community Health Administrative Rules
- C. Comprehensive Accreditation Manual for Behavioral Health Care, The Joint Commission, PC.10.10-PC.10.130
- D. Michigan Department of Community Health Technical Requirement for Behavior Treatment Plan Review Committees
- E. MDCH Medicaid Provider Manual 3.3 Behavioral Management Review

IV. DEFINITIONS:

A. AVERSIVE TECHNIQUES

Those techniques that require the deliberate infliction of unpleasant stimulation (stimuli which would be unpleasant to the average person or stimuli that would have a specific unpleasant effect on a particular person) to achieve the management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm. Examples of such techniques include use of mouthwash, water mist or other noxious substance to consequate behavior or to accomplish a negative association with target behavior, and use of nauseagenerating medication to establish a negative association with a target behavior or for directly consequating target behavior. Clinical techniques and practices established in the peer reviewed literature that are prescribed in the positive behavior support plan and that are voluntary and self-administered (e.g., exposure therapy for anxiety, masturbatory satiation for paraphilias) are not considered aversive for purposes of this policy. Otherwise, use of aversive techniques is prohibited.

B. BLOCKS

Defensive techniques used by staff to protect themselves when individuals hit or throw things at them. Blocks are the least restrictive of the physical intervention techniques and must be used in conjunction with non-physical intervention strategies such as Confrontation Avoidance, De-escalation and Communication skills.

C. COME-ALONGS

Come-Alongs are techniques used to assist in transporting or regaining self-control. Come-Alongs enable staff to safely move individuals while exerting only the amount of control required by the situation. They can be either very restrictive or very non-restrictive. In its simplest form a Come-Along can be

used to provide gentle helpful guidance to an individual who is disoriented or has difficulty walking. If necessary, however, the basic Come-Along position allows staff to quickly become more restrictive when interacting with individuals who must move but do not want to move.

D. HANDS DOWN

A release technique not intended to be a physical hold. This is used when an individual is flailing or attempting to self-abuse. Staff hands are used to shadow the movements of the individual or to offer light touch without applying pressure. Hands Down must be used in conjunction with non-physical intervention strategies such as Confrontation Avoidance, De-escalation or Communication Skills.

E. INTRUSIVE TECHNIQUES

Those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control of a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used to manage, control, or extinguish an individual's behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's condition. Use of intrusive techniques as defined here requires the review and approval by the Committee.

F. NON-PHYSICAL INTERVENTION

Strategies that promote a culture of gentleness and teach staff to help an individual calm before a situation escalates. Use of these techniques is required prior to implementing physical intervention. Different techniques will be used depending on the situation, but staff should be consistent in their actions. The techniques include Pro-Active Options, Communication Skills, Confrontation Avoidance, and De-escalation. They should be used regularly and naturally during interactions with individuals who display challenging behaviors.

G. PEER-REVIEWED LITERATURE

Scholarly works that typically represent the latest original research in the field, research that has been generally accepted by academic and professional peers for dissemination and discussion. Review panels are comprised of other researchers and scholars who use criteria such as "significance" and "methodology" to evaluate the research. Publication in peer-reviewed literature does not necessarily mean the research findings are true, but the findings are considered authoritative evidence for a claim whose validation typically comes as the research is further analyzed and its findings are applied and re-examined in different contexts or using varying theoretical frameworks.

H. PHYSICAL MANAGEMENT

A technique used by staff to restrict the movement of an individual by direct physical contact in order to prevent the individual from physically harming himself, herself, or others. Physical management will only by used on an emergency basis when the situation places the individual or others at imminent risk of physical harm. Physical management, as defined here, will not be included as a component of a positive behavior support plan. The term "physical management" does not include briefly holding an individual in order to comfort him or her or to demonstrate affection, or holding his/her hand. Physical management involving prone immobilization of an individual for behavioral control purposes is prohibited under any circumstances.

I. POSITIVE BEHAVIOR SUPPORT

A set of research-based strategies used to increase quality of life and decrease problem behavior by teaching new skills and making changes in a person's environment. Positive behavior support combines valued outcomes, behavioral and biomedical science, validated procedures, and systems change to enhance quality of life and reduce problem behaviors such as self-injury, aggression, property destruction, pica, defiance, and disruption.

J. PRACTICE OR TREATMENT GUIDELINES

Guidelines published by professional organizations such as the American Psychiatric Association (APA), or the federal government.

K. PRONE IMMOBILIZATION

Extended physical management of an individual in a prone (face down) position, usually on the floor, where force is applied to the individual's body in a manner that prevents him or her from moving out of the prone position.

L. RESTRAINT

The use of a physical or mechanical device used to restrict an individual's movement at the order of a physician. The use of physical or mechanical devices used as restraint is prohibited except in a state-operated facility or a licensed hospital. This definition excludes

- Anatomical or physical supports that are ordered by a physician, physical therapist or occupational therapist for the purpose of maintaining or improving an individual's physical functioning
- Protective devices which are defined as devices or physical barriers to prevent the individual from causing serious self-injury associated with documented and frequent incidents of the behavior and which are incorporated in the written individual plan of services through a positive behavior support plan which has been reviewed and

- approved by the Committee and received special consent from the individual or his/her legal representative.
- Safety devices required by law, such as car seat belts or child car seats used while riding in vehicles.

M. RESTRICTIVE TECHNIQUES

Those techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques used for the purposes of management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm, include prohibiting communication with others to achieve therapeutic objectives; prohibiting ordinary access to meals; using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Use of restrictive techniques requires the review and approval of the Behavior Treatment Committee.

N. SECLUSION

The placement of an individual in a room alone where egress is prevented by any means. Seclusion is prohibited except in a hospital or center operated by the department, a hospital licensed by the department, or a licensed child caring institution licensed under 1973 PA 116, MCL 722.111 to 722.128.

O. SPECIAL CONSENT

Obtaining the written consent of the individual, the legal guardian, the parent with legal custody of a minor child or a designated patient advocate prior to the implementation of any behavior treatment intervention that includes the use of intrusive or restrictive interventions or those which would otherwise entail violating the individual's rights. The general consent to the individualized plan of services and/or supports is not sufficient to authorize implementation of such a behavior treatment intervention. Implementation of a behavior treatment intervention without the special consent of the individual, guardian or parent of a minor individual may only occur when the individual has been adjudicated pursuant to the provisions of section 469a, 472a, 473, 515, 518, or 519 of the Mental Health Code.

P. STANDING WRAPAROUNDS

A restrictive technique for controlling an individual's activity. It is the most restrictive technique and should only be implemented when all other interventions have failed. Standing Wraparound should not be maintained any longer than necessary to assist the individual in regaining control. Time increases the risk of injury and undesirable side effects. As individuals regain self-control they should be gradually and cautiously released from the Wraparound.

- V. POLICY: Behavior treatment interventions will be guided by the following principles and practice.
 - A. Behavior treatment interventions for unprecedented and unpredicted crises or emergency occurrences of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of harm will be the least restrictive and least intrusive needed to prevent harm.
 - B. Positive Behavior Support Plans for non-emergent or continuing occurrences of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of harm will:
 - 1. Be based on the assessment of the individual, including strengths and deficits, and on the assessment of the target behaviors, including frequency, duration and intensity.
 - 2. Rule out physical, medical, and environmental (e.g., trauma, interpersonal relationships) conditions that might be the cause of the behaviors.
 - 3. Include in their development input from the individual and their person centered planning team in the selection of behavior treatment interventions and be written into the Person Centered Plan or as an addendum to the PCP.
 - 4. Be implemented across all environments or rationale given for why that is not appropriate.
 - 5. Be designed, supervised, monitored, changed or discontinued only by persons who have qualifications, training, experience and knowledge relating to behavior treatment interventions.
 - 6. Be implemented only by persons who are competent, supervised and trained in how to implement the plan.
 - 7. If they include restrictive or intrusive interventions, be designed to ameliorate or eliminate the need for such interventions in the future.
 - 8. Adhere to any legal psychiatric advance directive that is present for an adult with serious mental illness.
 - 9. Employ positive behavior supports and interventions, including specific interventions designed to develop functional abilities in major life activities, as the first and preferred approaches.
 - 10. Consider other kinds of behavior treatment or interventions that are supported by peer-reviewed literature or practice guidelines in conjunction with behavior supports and interventions, if positive behavior supports and interventions are documented to be unsuccessful.
 - 11. As a last resort when there is documentation that neither positive behavior supports and interventions nor other kinds of interventions were successful, propose restrictive or intrusive techniques, described herein, that will be reviewed and approved or disapproved by the Behavior Treatment Committee.
 - C. Positive Behavior Support Plans that include the use of aversive procedures will not be permitted.
 - D. Individuals receiving CMHCM services have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
 - E. Physical management will only be used on an emergency basis when the situation places the individual or others at imminent risk of physical harm and will be documented per agency requirements. Only those techniques approved by CMHCM, Block (not physical management), Hands Down, Come-Along and Standing Wraparound, will be used. Physical management, as defined herein, will not be included as a component of a Positive Behavior Support Plan. When a pattern of behavior indicates emergency physical management is likely to be required on an ongoing basis, the Person Centered Plan for the individual will include a statement that in the event the behavior of the individual puts the individual or others at imminent risk of physical harm staff will use the least restrictive, most effective form of emergency physical management needed to assure the safety of everyone. Physical management involving prone immobilization of an individual for behavioral control purposes is prohibited under any circumstances.
 - F. A Behavior Treatment Committee will:
 - 1. Be appointed by the Executive Director
 - 2. Have a minimum of three members.
 - 3. Have at least one member who is a full or limited licensed psychologist with specified training and experience in applied behavior analysis
 - 4. Have at least one member who is a licensed physician/ psychiatrist

- 5. Have at least one clinical representative from services who has expertise in working with people with mental illness and/or people with developmental disabilities.
- 6. Have a Recipient Rights Officer/Advisor serving as an ex-officio member of the committee.
- 7. Have two-year overlapping terms for members, who may be reappointed to consecutive terms.
- 8. At the discretion of the Committee, and with the consent of the individual whose treatment plan is being reviewed, allow participation by other non-voting attendees.
- G. The functions of the Behavior Treatment Committee are as follows:
 - 1. Review plans and behavioral data to assure that an intervention is necessary; that the intervention is the least restrictive effective intervention; and that the rights of the individual are protected.
 - 2. Disapprove any Positive Behavior Support Plan that proposes to use aversive techniques, physical management, or seclusion or restraint in a setting where it is prohibited by law or regulations.
 - 3. Determine whether causal analysis of the behavior has been performed, whether positive reinforcers have been identified and positive behavioral supports and interventions have been adequately pursued, and where these have not occurred disapprove any proposed plan for utilizing intrusive or restrictive techniques.
 - 4. Expeditiously review and approve or disapprove, in light of current peer-reviewed literature or practice guidelines, all Positive Behavior Support Plans proposing to utilize intrusive or restrictive techniques.
 - 5. For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. This review will occur no more than three months from the date of the last review, or more frequently if clinically indicated for the individual's condition, or when the individual requests the review as determined through the person-centered planning process. The more intrusive or restrictive the interventions, or the more frequently they are applied, the more often the entire Positive Behavior Support Plan should be reviewed by the Committee.
 - 6. Assure that inquiry has been made about any medical, psychological or other factors that the individual has which might put him/her at high risk of death, injury or trauma if subjected to intrusive or restrictive techniques.
 - 7. Advise the Executive Director regarding administrative and other policies and practices affecting behavior services, including staff training needs.
 - 8. Arrange for an evaluation of the Committee's effectiveness by stakeholders, including individuals who had approved plans, as well as family members and advocates.
 - 9. Quarterly track and report to the Performance Improvement Committee the use of all physical management or PRN medication for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the intervention, as well as:
 - a. Dates and numbers of interventions used
 - b. The settings (e.g., group home, day program) where behaviors and interventions occur
 - c. Behaviors that initiated the techniques
 - d. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention
 - e. Attempts to use positive behavioral supports
 - f. Behaviors that resulted in termination of the interventions
 - g. Length of time of each intervention
 - h. Staff development and training and supervisor guidance to reduce the use of these interventions
- H. The Behavior Treatment Committee will meet on a regular basis to review submitted plans that require committee action. If there is a need for emergency approval, two BTC members or one BTC member and one member of the Executive Leadership Team can provide the approval until the next scheduled meeting of the BTC.
- I. Two voting members will constitute a quorum.
- J. Any Committee member who has prepared a Positive Behavior Support Plan to be reviewed by the Committee will recuse himself/herself from the final decision-making.
- K. The Committee will select the chairperson and the chairperson will authorize a designee in their absence.

VI. PROCEDURE:

- A. Proposed plans, data and reports for BTC review must be received by the committee chairperson/designee at least five working days prior to the next scheduled meeting.
- B. Staff submitting a plan for BTC review will assure that the following information is submitted:
 - 1. Proposed Positive Behavior Support Plan with attached Positive Behavior Support Plan Summary Form CMHCM-200.
 - 2. Evidence that the plan was developed as part of the person-centered planning process.
 - 3. Results of assessments performed to rule out relevant physical, medical and environmental causes of the problem behavior.
 - 4. Results of inquiries about any medical, psychological or other factors that might put the individual subjected to intrusive or restrictive techniques at high risk of death, injury or trauma.
 - 5. Evidence of the kinds of positive behavioral supports or interventions, including their amount, scope and duration that have been attempted to ameliorate the behavior and have proved to be unsuccessful.
 - 6. Evidence of continued efforts to find other options.
 - 7. Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention.
 - 8. References to the literature should be included, and where the intervention has limited or no support in the literature, why the plan is the best option available.
- C. The following information will be available in the proposed plan.
 - 1. Purpose of the plan and the target behaviors.
 - 2. Functional behavioral assessment.
 - 3. Less restrictive measures that have been tried/justification for restrictiveness.
 - 4. Goals and objectives.
 - 5. Positive reinforcement of adaptive/replacement behaviors and schedule utilized.
 - 6. Maximum time limits for interventions.
 - 7. Method of data collection.
 - 8. Baseline data.
 - 9. Current data.
 - 10. The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s).
- D. If the plan is intrusive or restrictive, guardian approval is required before implementation.
- E. Behavior data and reports of progress using approved plans will be submitted to the BTC on the Positive Behavior Support Staff Report Form CMHCM-920 at a frequency determined by the BTC. Use of emergency physical management, emergency PRN medications and approved intrusive or restrictive interventions will be recorded on the Positive Behavior Support Intervention Data Form CMHCM-919, submitted to the assigned case manager and forwarded to the BTC for review and feedback.
- F. In order to minimize the possibility of re-traumatization of those who have experienced earlier trauma, staff will be trained in and expected to utilize de-escalation in crisis situations. Plans will include reference to an individual's statement of preference for crisis response.
- G. Staff hired as Case Managers, and their Supervisors will have a human service degree. Within 30 days of hire or within 30 days of approval and availability of the materials to those already employed at the agency, all Case Managers, and their Supervisors will read, test, and pass the following three items in the Essential Learning online training system: 1) this policy, 2) the course titled *Principles of Positive Behavior Support for Individuals with Developmental Disabilities*, and 3) the five page article by Developmental Enhancement, PLC (David Laman) titled *Positive Behavior Support*. Successful completion initially of documents #1 and #2, and annually thereafter of #3 is required in order for the supervisor to rate the supervisee as demonstrating competence at behavior services. In addition to the three readings with tests, attendance is required at an annual workshop on a topic related to positive behavior support. Additional readings may be recommended and required by the BTC. De-escalation training will be offered by the CMHCM Training Department to all staff who may encounter individuals

in need of that approach. Additional, in-depth training and positive support plan writing can be provided on an as needed basis through behavioral consultation for particularly challenging situations that have not been impacted by previous positive behavior support plans. Also, strongly encouraged are ongoing discussions in staff meetings and/or in supervision of some aspect of writing positive behavior support plans.

- H. Even in emergency situations, staff will only use physical management techniques for which they have been trained. The only exception is that it is not considered unreasonable force to take whatever action is needed to protect an individual from something with a high risk of very serious physical harm, such as running out into traffic.
 - 1. It is essential that all staff learn how each individual communicates their wants and needs, particularly those whose primary method of communication is non-verbal.
 - 2. Blocks (not physical management), Hands Down, Come-Along and Standing Wraparound are the techniques approved by CMHCM to be used by staff trained in how to implement them, and only to be used in emergency situations when there is imminent risk of physical harm.
 - 3. The CMHCM Training Department will offer training to CMHCM staff and to contract providers who will then train their staff. The training will emphasize positive approaches and include de-escalation and confrontation avoidance, as well as how to implement the four approved techniques named in #2.
 - 4. Records will be kept of who has been trained on what date to implement and/or to train the techniques. Provider trainers will document reviewing the techniques with trained staff every three months. Providers will notify CMHCM when they need additional trainers trained. CMHCM training staff will be available to consult with providers after the initial training.
 - 5. Case managers will determine before placement whether staff working with a specific individual need to be trained in CMHCM-approved techniques to be used in emergency situations when there is imminent risk of physical harm.

Approved: 10/1/01 Revised: 12/17/02 Revised: 1/25/05 Revised: 3/28/06 Revised: 11/28/06 Revised: 4/13/07 Revised: 1/27/09 Revised: 3/26/09 Revised: 7/23/09 Revised: 3/30/10 Revised: 5/25/10

Emergency Physical Intervention Skill Demonstrations				
Name:		Pass / Fail		
Date:				
Physical management will only be used on an emergency basis when the situation places the individual or others at imminent risk of physical harm and will be documented per agency requirements.				
Only those techniques approved by CMHCM, Block (not physical management), Hands Down, Come-Along and Standing Wraparound, will be used.				
When a pattern of behavior indicates emergency physical management is likely to be required on an ongoing basis, the Person Centered Plan for the individual will include a statement that in the event the behavior of the individual puts the individual or others at imminent risk of physical harm staff will use the least restrictive, most effective form of emergency physical management needed to assure the safety of everyone.				
DIRECTIONS Mark a "C" in the blank if the statement is "Correct" Mark an "I" in the blank if the statement is "Incorrect" Mark an "N/A" in the blank if the statement is "Non-applicable" for a certain situation				
TECHNIQUES TO PROTECT YOURSELF AND OTHERS				
BLOCKS				
	nch/Flying Object:			
	Feet apart, body turned, balance maintained.	I.P		
	2. Arms positioned to protect head and face. Main	tain eye contact.		
-	B. Palms toward self, hands closed.			
	Eye contact, talks to the person (using C.A.T.) c.			
	5. Blows are absorbed on forearms as moving awa	y from person.		
Handa Dawa				
Hands [a nalm anan ayar tha hand/a) of the narran		
1.	1 1 1			
2.	surface.	te to the person's level of resistance, to his/her lap or to a flat		
3.				
 	9 1	may "chadaw" the mayoments of the hand or offer light touch		
4.	without pressure by keeping your hands over the	may "shadow" the movements of the hand or offer light touch		
		person's nanus.		
5.	Continue to talk to person using C.A.T.			
One person come-along (used to protect someone from falling during ambulation).				
1.	Stands next to, slightly behind person.	iy during ambulation).		
2.		with hand closest to person		
3.	Holds inside of person's forearm (just above wrist			
 	Holds person's upper arm (between elbow and sh	,		
4.	Uses hip, forearm, upper arm to assist/guide pers	oui ioiwaid.		

DIRECTIONS:

COME-ALONGS:

Mark a "C" in the blank if the statement is "Correct"

Mark an "I" in the blank if the statement is "Incorrect"

Mark an "N/A" in the blank if the statement is "Non-applicable" for a certain situation

These techniques are considered to be EMERGENCY INTERVENTIONS. They are the most restrictive of all interventions and should only be used as a last resort. For techniques which involve the use of two staff it is vitally important that the staff performing these techniques communicate with each other. These techniques should always be used in conjunction with non-physical intervention techniques. The primary purpose of these techniques is to assist the person in regaining self control.

TECHNIQUES USED TO ASSIST WITH REGAINING SELF CONTROL

A. One-person Come-along:				
1	1.	Stands next to, slightly behind person.		
2	2.	Holds inside of person's forearm (just above wrist) with hand closest to person.		
3	3.	Holds person's upper arm (between elbow and shoulder) with outside hand, tucks arm back.		
	4.	Uses hip, forearm, upper arm to assist/guide person forward.		
B. Two-person forward Come-along:				
1	1.	Each staff person communicates their roles and cues for each other.		
	2.	Each staff person correctly performs the one person come-along (one staff on each side).		
3	3.	Carefully directs the person forward.		
HOLDS:				
A. Wrap-around from front: (Review flail block)				
	1.	Grasps person's wrist (as if shaking hands) pulling person towards you, step behind them.		
2	2.	With free forearm, blocks persons uncontrolled arm, pinning it across person's chest.		
3	3.	Transfers controlled wrist to free hand, grasps person's trapped wrist with other hand, locks elbows at waist		
		level.		
	4.	In proper stance, hip toward person's back, shift weight or step back to make person slightly off balance.		
5	5.	Protect head, uses hip and arms to maintain stance and control of situation.		
B. Wrap-around from behind:				
1	1.	Bump both arms from behind with your forearms placed above the person's elbows, forcing arms to cross in		
		front of the person.		
2	2.	Grasp wrist of arm that is on top, pinning other arm.		
3	3.	Grasp wrist of pinned arm, lock elbows.		
	4.	In proper stance, hip toward person's back, shift weight or step back to make person slightly off balance.		
Ę	5.	Protect head, uses hip and arms to maintain stance and control of situation.		
Because these techniques are taught in a controlled setting at slow speed, proficiency during actual use cannot be				
guaranteed.				
It is strongly recommended that frequent review and practice of the techniques is necessary to improve proficiency and				
speed after the initial training.				
*Starred items indicate a special note for additional review and practice.				
COMMENTS:				
Student's Signature: Trainer's Signature:				

RESOURCE MATERIALS

Some content in this section has been adapted from the following resource materials:

The original Department of Mental Health curriculum- Non-Physical and Physical Intervention modules which were based on the NAPPI techniques. 1985

Providing Residential Services in Community Settings: A Training Guide Michigan Department of Human Services www.michigan.gov/afchfa

Licensing Rules for Adult Foster Care family Homes
http://www.michigan.gov/documents/dhs/BCAL-PUB-0332_281384_7.pdf
Licensing Rules for Adult foster Care large Group Homes (13-20)
http://www.michigan.gov/documents/dhs/DHS-BCAL-PUB-334_276575_7.pdf
Licensing Rules for Adult Foster Care Group Homes (12 or Less)
http://www.michigan.gov/documents/dhs/BCAL-PUB-0333_241598_7.pdf
Certification of Specialized Programs Offered In Adult Foster Care Home To Clients With Mental Illness or Developmental Disability
http://www.michigan.gov/documents/dhs/BCAL-PUB-0336_214333_7.pdf

Michigan Department of Community Health (MDCH) http://www.michigan.gov/mdch

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