Stark County Board of Developmental Disabilities

BEHAVIOR SUPPORT

POLICY

The Stark County Board of Developmental Disabilities (SCBDD) is committed to helping individuals who have intellectual and developmental disabilities form meaningful social relationships and attain valued roles in their home, school, work environments, and in the community. At times, however, challenging behavior interferes with this endeavor, limiting such relationships and roles. Therefore, SCBDD fosters and oversees a wide range of person-centered, behavior support methods focused on teaching age-appropriate and socially acceptable behavior in a positive and supportive manner, by the least restrictive means, and utilizing the least intrusive forms of service.

Methods to support positive behavioral change are developed by the individual (to the extent possible) and his/her team, and are based upon the results of a functional analysis of the identified challenging behavior(s) in order to: 1) promote an individual's personal growth, development and independence, and 2) increase an individual's choice in daily decision-making and self-management of behavior.

As mandated by Ohio Administrative Code (OAC) 5123:2-2-06, behavior support methods are employed with sufficient safeguards and supervision to ensure that the dignity, respect, safety, health, welfare, due process, and civil and human rights of individuals receiving services are adequately protected. Restrictive measures are used only after less restrictive techniques have been documented as ineffective, or when an individual's behavior poses a risk of harm to self or others and/or are very likely to result in the individual being the subject of a legal sanction.

The Superintendent is authorized to establish and revise these procedures as needed.

Source: Ohio Revised Code

Ohio Administrative Code 5123:2-2-06

Historical Resolution Information		Reviewer(s):
Date	**Resolution Number**	Superintendent
3/17/12	03-27-12	Director of SSA/ Investigative Services
5/16/15	05-28-15	
6/26/18	06-34-18	

BEHAVIOR SUPPORT

PROCEDURES

I. Overview

The Stark County Board of Developmental Disabilities (SCBDD) is committed to supporting individuals with developmental disabilities in a caring and responsive manner that promotes dignity, respect, and trust and with recognition that they are equal citizens with the same rights and personal freedoms granted to Ohioans without developmental disabilities. Services and supports identified in the Individual Service Plan (ISP), including behavior support strategies, are based on a comprehensive understanding of the individual and the reasons for his or her actions. When developing supports, effort is directed at creating opportunities for individuals to exercise choice in matters affecting their everyday lives and supporting individuals to make choices that yield positive outcomes. When challenging behaviors interfere with the attainment of educational, vocational, and personal goals, positive behavior support strategies and natural consequences of behavior are the most desirable behavior support methods and typically have the best long-term effects. However, when positive strategies are determined to be unsuccessful in reducing challenging behaviors, any resulting use of planned restrictive measures should be the least restrictive and least intrusive possible needed to ensure health and welfare and promote positive community connections for individuals.

II. Hierarchy of Interventions

Behavior support strategies may involve a number of interventions, with the primary focus on the development of positive skills and proactive strategies that aid in minimizing the health and safety risks of challenging behaviors. This section outlines the range of behavior support strategies as they increase from low risk/low restrictiveness to high risk/high restrictiveness, and finally to prohibited interventions.

A. Positive Interventions

Positive Behavioral Supports (PBS) influence the display of challenging behaviors by addressing the situation through the use of both proactive and reactive strategies.

1. **Proactive Strategies** are used regardless of whether challenging behaviors are being displayed and may include: schedule/routine/activity changes; environmental changes; social/interpersonal changes; educational opportunities; increased supervision; and/or positive reinforcement.
2. **Reactive Strategies** are responses to challenging behaviors that involve minimal risk to the individual, and may include: natural consequences; voluntary time-away; environmental correction (*NOTE: The individual is not required to provide monetary compensation for any item damaged/destroyed or for materials used to restore the environment.*); and accompanying using occasional light touch (*NOTE:*

The individual MUST be cooperative during accompanying; otherwise, this is considered an aversive manual restraint.).

B. Supports Used for Children and Those Enrolled in Educational Programs

SCBDD recognizes that individuals under the age of 18 are considered children, and certain rights restrictions are considered to be age-appropriate (i.e., restrictions on bedtime, candy on demand, smoking, computer access to questionable sites, etc.). Behavior support strategies for children will consider age of the individual, and be developed with the understanding that they must be age-appropriate. These age-appropriate restrictions will not be considered restrictive measures and therefore will not be reviewed by the Human Rights Committee (HRC). The use of restraints and/or time-out are restrictive measures regardless of the individual's age and will follow the process outlined below for the development of restrictive measures and approval by HRC .

While educational programs follow the rules outlined in OAC 3301-35-15 *Standards for the implementation of positive behavior intervention supports and the use of restraint and seclusion*, SCBDD educational programs shall also follow the rules outlined in OAC 5123:2-2-06 *Behavioral support strategies that include restrictive measures* [note that the definition of seclusion in OAC 3301-35-15 is similar to the definition of a time-out in OAC 5123:2-2-06; the term time-out is used throughout these procedures].

In SCBDD's educational programs, the following supports are appropriate for use:

1. **Eastgate Early Childhood and Family Center**:
   a. **Thinking chair –** The child sits for a period of time (equal to his/her age) in a different part of the classroom in order to calm down and get ready to be with the group again. The child sitting in the "Thinking Chair" is supervised by a classroom staff member at all times.
   b. **SCBDD Policy 5.10, Preschool Discipline Program**, further describes supports used in that program.
2. **School-age Programs**:
   a. **Contingent removal of materials –** The activity with which the student is involved is removed for a period of time, not exceeding limits determined by the school team.
   b. **In-school suspension/detention –** The student is assigned to this option for a designated period of time in lieu of out-of-school suspension. Instructional time can continue without interruption and special academic help can be provided as needed.
   c. **Positive Behavior Interventions and Supports (PBIS) –** The utilization of a system of positive interactions to recognize and reward good behavior through classroom management, school-wide initiatives, and referral/observation with Adaptive Learning Program.

3. **Suspension/Removal/Expulsion of Students**:
   The use of suspension, removal, and expulsion of students follow Ohio Department of Education and Ohio Special Education Regulations, including the *Operating Standards for Ohio's Educational Agencies Serving Children with Disabilities,* and are outlined in SCBDD's Policy 5.14.

C. Restrictive Measures

Restrictive measures are strategies that are unpleasant, intrusive or uncomfortable in response to challenging behaviors. A behavioral support strategy may include individualized searches for dangerous objects, time-out or restraint (manual/mechanical/chemical) only when an individual's actions pose risk of harm. Risk of harm means there exists a direct and serious risk of physical harm to the individual or another person. For risk of harm, the individual must be capable of causing physical harm to self or others and the individual must be causing physical harm or very likely to begin causing physical harm. Appropriate restrictive measures are easily understood by both the individual and the implementers, and require Human Rights Committee (HRC) approval and oversight. If any restrictive measure is utilized without obtaining required consent and approval, or if the use of a restrictive measure results in injury, a Major Unusual Incident (MUI) Report must be submitted. Examples of restrictive measures follow:

1. **Individualized Searches for Dangerous Objects** – Searching an individual's locker, person, or property for dangerous objects (e.g., sharps, weapons, etc.).
   a. Based on the comprehensive circumstances (e.g. aggressive behavior, reports, immediate access, relevant history of similar behavior, etc.), the use of searches requires reasonable individualized suspicion that the individual is in possession of the dangerous object.
   b. The search must be limited in scope to the objectives of the search (e.g., pockets of clothing worn at the time versus all possessions) and duration, and both the scope and duration must be noted in the ISP.
   c. Preauthorization of routine searches for dangerous objects requires SCBDD to provide the individual with notice of intent and the right to a hearing where the individual/guardian or the parent of a minor can present a meaningful objection to the plan. This is made available during the team meeting, on an incident-by-incident basis, and any other occasion when requested.
2. **Time-out** – Time-out means confining an individual in a room or area and preventing the individual from leaving the room or area by applying physical force or by closing a door or constructing another barrier, including placement in such a room or area when a staff person remains in the room or area. Time-out does not include periods when an individual, for a limited and specified time, is separated from others in an unlocked room or area for the purpose of self-regulating and controlling his or her own behavior and is not physically restrained or prevented from leaving the room or area by physical barriers. Time-out interventions include the following characteristics:

a. The individual does not choose to leave the reinforcing environment and does not determine when to return to it.
b. Time-out shall not exceed thirty minutes for any one incident nor one hour in any twenty-four hour period.
c. A time-out room or area shall not be key-locked, but the door may be held shut by a staff person or by a mechanism that requires constant physical pressure from a staff person to keep the mechanism engaged.
d. The time-out room or area must be adequately lighted and ventilated, and must provide a safe environment for the individual.
e. The individual must be protected from hazardous conditions, including but not limited to, the presence of sharp corners and objects, uncovered light fixtures, or unprotected electrical outlets.
f. The individual in a time-out must receive constant visual supervision by staff, and a record of time-out observations must be kept.
g. Time-out is discontinued immediately once risk of harm has passed or if the individual engages in self-abuse, becomes incontinent, or shows other signs of illness.

3. **Restraint** – Restricting free movement of, normal functioning of, normal access to, or normal responsiveness to a portion or portions of an individual's head, limbs or body through manual, mechanical or chemical means. Use of restraint shall cease immediately once risk of harm has passed.
   a. **Manual Restraint** – Use of a physical, hands-on method, but never in a prone restraint, to restrict or limit movement, using sufficient force to cause the possibility of injury and includes holding or disabling an individual's wheelchair or other mobility device. Manual restraint does not include a method that is routinely used during a medical procedure for patients without developmental disabilities. Manual restraint interventions include the following characteristics:
      i. An individual in a manual restraint shall be under constant visual supervision by staff.
      ii. The manual restraint technique used must be from a provider-approved crisis prevention and intervention program/training, and they must ensure that all staff members who implement approved restrictive measures, which incorporate the use of manual restraint, have appropriate, current certification in their chosen program/training. Providers are responsible for:
         - Notifying the Service and Support Administrator (SSA) of the training program they are choosing to use, and
         - Providing documentation of specific interventions inherent in the program.

      SCBDD does not specify the type of crisis prevention and intervention program/training a provider must use. However, providers should

ensure that their chosen program contains training on both non-physical and physical techniques that are designed to reduce the risk of injury. Effective crisis programs/training include the following components: using the least amount of external management necessary in every situation; utilizing a graded system of alternatives; embracing the team approach; reinforcing self-control; and relying on knowledge, skill, and timing rather than size and strength.

b. **Mechanical Restraint –** Use of a device, but never in a prone restraint, to control an identified action by restricting an individual's movement or functioning. Mechanical restraints are typically those that the individual cannot easily remove, are not permitted to remove, or are put back on upon their removal. Examples of mechanical restraints follow:
   i. A restraint device used in any vehicle, seatbelts adapted on buses, transportation safety vests, wrap-around seatbelts, etc.
   ii. Gloves, aprons, coveralls, helmets, etc.

   The following are not considered mechanical restraints:
   i. A seat belt of a type found in an ordinary passenger vehicle or an age-appropriate child safety seat.
   ii. A medically-necessary device (such as a wheelchair seatbelt or a gait belt) used for supporting or positioning an individual's body.
   iii. A device that is routinely used during a medical procedure for patients without developmental disabilities.
   iv. Medical restraints used to promote healing or prevent injury in individuals who do not have an ongoing behavior problem as the source of the medical problem. Use of medical restraints must be determined and monitored by the interdisciplinary team with nurse or physician consultation.

c. **Chemical restraint –** Prescribed medication for the purpose of modifying, diminishing, controlling, or altering a specific behavior. Medication for behavior control must be prescribed by and under the supervision of a licensed physician who is involved in the interdisciplinary planning process. Examples of chemical restraints follow:
   i. Medication prescribed solely for the purpose of behavior control, in the absence of a psychiatric diagnosis.
   ii. Medication not typically prescribed as an accepted treatment for a particular identified problem or disorder (i.e., "off-label" use).
   iii. PRN or as-needed psychotropic medication.

   Chemical restraint does not include:
   i. Medication prescribed for the treatment of a diagnosed disorder identified in the "Diagnostic and Statistical Manual of Mental Disorders" (fifth edition).

ii. Medication prescribed for the treatment of a seizure disorder.
iii. Medication that is routinely prescribed in conjunction with a medical procedure for patients without developmental disabilities.
iv. PRN medication prescribed in order to reduce anxiety and used only in anticipation of the individual undergoing a planned medical and/or dental procedure.

A behavioral support strategy may include restriction of an individual's rights only when an individual's actions pose risk of harm or are very likely to result in the individual being the subject of a legal sanction such as eviction, arrest, or incarceration. Absent risk of harm or likelihood of legal sanction, an individual's rights shall not be restricted (e.g., by imposition of arbitrary schedules or limitation on consumption of food, beverages, or tobacco products).

4. **Restriction of an individual's rights** as enumerated in section 5123.62 of the Revised Code. Rights restrictions involve limiting an individual's access to typical activities, possessions, experiences, or freedoms in order to either prevent harm or minimize the risks associated with a challenging behavior. When determining if an intervention represents a restriction of an individual's rights, the functioning level of the individual is considered. Restrictive interventions can be implemented either proactively or in response to a display of the challenging behavior. Examples of restrictive interventions include: video/audio monitors, motion sensors, dietary restrictions (other than texture-related issues due to chewing/swallowing needs), locked doors/windows, alarms, phone/TV/internet restrictions, and/or family visit restrictions.

D. Prohibited Measures

Prohibited measure means a method that shall not be used by persons or entities providing specialized services. SCBDD prohibits the use of any action which compromises the individual's health, safety or dignity. A behavioral support strategy shall never include prohibited measures. Examples of prohibited measures follow:

1. Prone restraint - A method of intervention where an individual's face and/or frontal part of his or her body is placed in a downward position touching any surface for any amount of time.
2. Use of a manual restraint or mechanical restraint that has the potential to inhibit or restrict an individual's ability to breathe or that is medically contraindicated.
3. Use of a manual restraint or mechanical restraint that causes pain or harm to an individual.
4. Disabling an individual's communication device.
5. Denial of breakfast, lunch, dinner, snacks, or beverages.
6. Placing an individual in a room with no light.
7. Subjecting an individual to damaging or painful sound.
8. Application of electric shock to an individual's body.
9. Subjecting an individual to any humiliating or derogatory treatment.

10. Squirting an individual with any substance as an inducement or consequence for behavior.
11. Using any restrictive measure for punishment, retaliation, instruction or teaching, convenience of providers, or as a substitute for specialized services.
12. Using an individual's own funds for reinforcement of desirable behaviors (i.e., re-earning something that is already owned).
13. The use of restraint or time-out for behaviors that do not pose a risk of harm to self or others.
14. The use of a restriction of an individual's rights for behaviors that do not pose a risk or harm to self or others or the likelihood of a legal sanction.
15. Written physician's orders for the use of a restrictive measure used in response to a behavior or to prevent behavior without appropriate HRC review and oversight.

III. Process for Supporting Individuals with Challenging Behaviors

Effective behavior support is a process, not just an end product or plan. The following steps are intended to serve as a framework for the process of providing behavior support and, specifically, to give guidance when writing an ISP.

A. Rule Out Medical Factors

Whenever challenging behavior(s) begin to interfere with the individual's daily functioning and attainment of personal goals, the individual must first be evaluated by a medical professional to rule out any potential medical issues that may be contributing to the challenging behavior(s).

B. Problem Identification

Direct observation of challenging behaviors, trends and patterns of Unusual Incidents (UI's) and MUI's, and/or the following types of behavioral characteristics may serve as factors indicating the need for behavioral supports:

1. The behavior threatens the health or safety of the individual.
2. The behavior significantly interferes with learning or the attainment of the individual's goals.
3. The behavior is likely to become serious in the near future if not acknowledged, assessed and supported.
4. The behavior is dangerous to others.
5. The behavior interferes with community acceptance.

Once a need for behavioral supports is identified, the SSA responsible for the individual's plan initiates the assessment process to determine the level of supports required.

C. Assessment and Hypothesis Development

The goal of the assessment process is to define the target behaviors to increase and decrease, and to understand the possible causes of the behavior. While assessment activities can be formal (e.g., tests or assessment instruments) and informal (e.g., interviews with caregivers, reviews of files and documents, etc.), the effectiveness of the assessment is more dependent on the quality of the process than on the specific instrument utilized. The following elements are critical to the assessment process:

1. **Clearly Defined Target Behaviors –** Target behaviors must be defined in measurable and observable terms so that everyone involved is focused on the same behaviors.
2. **Baseline Data Collection –** The frequency at which the target behaviors occurred prior to implementation of an intervention (i.e., the baseline data) is collected. Baseline data can then be compared to the data collected following implementation of a strategy to determine the effectiveness of the strategy.
3. **Functional Analysis –** A functional analysis identifies how the behavior relates to the environment (i.e., What does individual gain from the behavior?) and answers the following questions:
    a. What are the characteristics of the behavior (frequency, intensity and duration)?
    b. What happens before the behavior occurs (antecedent)?
    c. What happens after the behavior (consequence)?
    d. What has changed (if anything) in the person's life?
    e. Where does the behavior occur?
    f. Does the challenging behavior look the same in all environments?
4. **Trauma-Informed Considerations –** An inquiry into the possible history of trauma and a clear analysis of how any such trauma may be related to the current behaviors, as well as, the implications for developing interventions.

Using the results of the behavior assessment, the team develops interventions which may be implemented through modifying the individual's ISP, initiating a referral for specialized services, developing positive behavior supports, or, as a last resort, developing restrictive measures.

D. Positive Behavior Support Development and Implementation

Positive behavior supports (PBS) are added to the ISP during the initial writing of the plan, at an annual revision, or through the addendum process. PBS do not require HRC approval and oversight.

E. Restrictive Measures Development and Implementation

Restrictive measures are developed only when necessary to keep people safe. Once the team determines that PBSs have been ineffective and recommends the development of a restrictive measure, the SSA initiates the development process based on the results of

the behavior assessment and team recommendations. As the restrictive measure is being developed, the SSA ensures that the recommended strategies are the least restrictive strategies appropriate for supporting the individual to change, eliminate and/or modify the challenging behavior and/or learn socially acceptable responses. Restrictive measures require HRC approval and oversight. (See Section IV., Levels of Review.)

1. **Enhancing Quality of Life -** The focus of a behavioral support strategy shall be creation of supportive environments that enhance the individual's quality of life. Effort is directed at:
    a. Mitigating risk of harm or likelihood of legal sanction;
    b. Reducing and ultimately eliminating the need for restrictive measures; and
    c. Ensuring individuals are in environments where they have access to preferred activities and are less likely to engage in unsafe actions due to boredom, frustration, lack of effective communication, or unrecognized health problems.
2. **A Behavioral Support Strategy That Includes Restrictive Measures Requires**:
    a. Documentation that demonstrates that positive and non-restrictive measures have been employed and have been determined ineffective;
    b. An assessment conducted within the past twelve months that clearly describes:
        i. The behavior that poses risk of harm or likelihood of legal sanction;
        ii. The level of harm or type of legal sanction that could reasonably be expected to occur with the behavior;
        iii. When the behavior is likely to occur; and
        iv. The individual's interpersonal, environmental, medical, mental health, and emotional needs and other motivational factors that may be contributing to the behavior;
    c. Strategies are easily understood by plan implementers and the individual;
    d. Strategies are designed in a manner that promotes healing, recovery, and emotional wellbeing based on understanding and consideration of the individual's history of traumatic experiences as a means to gain insight into origins and patterns of the individual's actions;
    e. Strategies are data-driven with the goal of improving outcomes for the individual over time and describe behaviors to be increased or decreased in terms of baseline data about behaviors to be increased or decreased;
    f. Recognition of the role environment plays in behavior;
    g. Capitalizing on the individual's strengths to meet challenges and needs;
    h. Delineating measures to be implemented and identify those who are responsible for implementation;
    i. Specifying the steps needed to ensure the safety of the individual and others;
    j. Identifying, as applicable, needed services and supports to assist the individual in meeting court-ordered community controls such as mandated sex offender registration, drug-testing, or participation in mental health treatment; and

k. Outlining, as applicable, necessary coordination with other entities (e.g., courts, prisons, hospitals, and law enforcement) charged with the individual's care, confinement, or reentry to the community.

3. **Implementation of Restrictive Measures**:
   a. Restrictive measures shall be implemented with sufficient safeguards and supervision to ensure the health, welfare, and rights of individuals receiving specialized services.
   b. The use of restrictive measures is discontinued if there is evidence it could result in serious harm or injury to the individual or does not achieve the desired results as defined in the ISP.
   c. Any use of restrictive measures that results in an injury or that is used in an unapproved manner or without obtaining required consent, approval, or oversight is reported as a MUI.
   d. SCBDD must notify the Ohio Department of Developmental Disabilities (DODD) of ISPs that include restrictive measures after securing approval by the HRC and prior to implementation of a behavioral support strategy that includes restrictive measures.
   e. Each person providing specialized services to an individual with a behavioral support strategy that includes restrictive measures shall successfully complete training in the strategy prior to serving the individual. All training documentation is maintained by the provider for review by SCBDD upon request and must include: 1) Date of training, 2) Type of training, 3) Printed name of staff member(s) being trained, 4) Signature of staff member(s) being trained, and 5) Title of staff member(s) being trained.
   f. The SSA may assist by training a designated contact person in each provider agency from which the individual is receiving services. The contact person or designee:
      i. Trains all of the staff members in his/her agency who work with the individual for whom the restrictive measures were developed (both current and subsequently hired staff members) prior to the staff member’s implementation of the restrictive measures,
      ii. Ensures documentation of training and trainees,
      iii. Provides the SSA with documentation of training and trainees,
      iv. Provides ongoing training to staff, relevant to changes or modifications, and additional training to staff in the agency who fail to accurately implement the restrictive measures.
   g. Provider agencies must ensure that all staff members who implement approved restrictive measures that incorporate the use of manual restraint have appropriate, current certification in their agency’s chosen crisis program. Documentation regarding staff training must be submitted to SCBDD upon request.

4. **Authorship Requirements** - Persons who conduct assessments and develop behavioral support strategies that include restrictive measures shall:
   a. Hold professional license or certification issued by the Ohio board of psychology; the state medical board of Ohio; or the Ohio counselor, social worker, and marriage and family therapist board; or
   b. Hold a certificate to practice as a certified Ohio behavior analyst pursuant to section 4783.04 of the Revised Code; or
   c. Hold a bachelor's or graduate-level degree from an accredited college or university and have at least three years of paid, full-time (or equivalent part-time) experience in developing and/or implementing behavioral support and/or risk reduction strategies or plans.
5. **When Restrictive Measures are Deemed Necessary, the Qualified SSA, Shall**:
   a. Ensure the strategy is developed in accordance with the principles of person-centered planning and incorporated as an integral part of the ISP.
   b. Secure informed consent of the individual or the individual's guardian, as applicable.
   c. Provide an individual or the individual's guardian, as applicable, with written notification and explanation of the individual's or guardian's right to seek administrative resolution if he or she is dissatisfied with the strategy or the process used for its development.
   d. Submit to the HRC documentation based upon the assessment that clearly indicates risk of harm or likelihood of legal sanction described in observable and measurable terms and ensure the strategy is reviewed and approved by the HRC prior to implementation and whenever the behavioral support strategy is revised to add restrictive measures, but no less than once per year.
   e. Ensure the strategy is reviewed by the individual and the team at least every ninety days to determine and document the effectiveness of the strategy and whether the strategy should be continued, discontinued, or revised. A decision to continue the strategy shall be based upon review of up-to-date information which indicates risk of harm or likelihood of legal sanction is still present.
   f. Ensure that a restrictive measure is temporary in nature and outlines the steps to restore right or eliminate the restrictive measure.

IV. Levels of Review

A. **Informed Consent** – The documented written agreement to allow a proposed action, treatment, or service to happen after full disclosure provided in a manner the individual or his or her guardian understands, of the relevant facts necessary to make the decision. Informed consent includes knowledge of the following: the risks and benefits of the action, treatment, or service; the risks and benefits of the alternatives to the action, treatment, or service; and the right to refuse the action, treatment, or service. The individual or his or her guardian, as applicable, may revoke informed

consent at any time. Informed consent by the individual/guardian, or the individual's parent (if individual is a minor), is requested prior to the review of the restrictive measures by the HRC. When informed consent cannot be documented in writing at the time it is obtained, such consent must be documented in writing within three days of the implementation of the restrictive measures. Informed consent is updated at least annually and is required for all plan revisions. Informed consent is finalized by informing the individual/guardian, or parent of a minor, of his/her due process and/or Medicaid State Hearing rights.

B. **Team Approval** – Team approval is required for all restrictive measures, and is fulfilled by written documentation of approval, including signatures of team members and dates when approval was given. Team approval is updated at least annually and is required for all plan revisions.

C. **Human Rights Committee (HRC)** – The HRC safeguards individuals' rights and protects individuals from physical, emotional, and psychological harm. All restrictive measures are reviewed at least annually, prior to their implementation dates. The SSA is responsible for seeking review from the HRC.

1. **Membership** - The HRC consists of the following members:
    a. Chairperson(s) – SCBDD administrative staff(s) appointed by the SSA Director.
    b. Members - A minimum of eight members are appointed by the SSA Director/HRC Chairperson(s), or designee, and includes:
        i. At least one individual who receives or is eligible to receive specialized services;
        ii. Qualified persons who have either experience or training in contemporary practices for behavioral support; and
        iii. A balance of representatives from each of the following two groups:
            - Individuals who receive or are eligible to receive specialized services or family members or guardians of individuals who receive or are eligible to receive specialized services; and
            - County boards or providers.
    c. Members do not review or approve any restrictive measures in which they participated in the development or will participate in the implementation.
    d. Members of the HRC shall receive department-approved training within three months of appointment to the committee in: rights of individuals as enumerated in section 5123.62 of the Revised Code, person-centered planning, informed consent, confidentiality, and the requirements of the behavior support strategies rule 5123:2-2-06.
    e. Members of the HRC shall annually receive department-approved training in relative topics which may include but are not limited to: self-advocacy and self-determination; role of guardians and section 5126.043 of the Revised Code; effect of traumatic experiences on behavior; and court-ordered

community controls and the role of the court, the county board, and the human rights committee.

2. **Meetings**:
    a. HRC meets regularly, at least once per month.
    b. The presence of four HRC members constitutes a quorum. No action is taken unless a quorum is present, except for emergency approvals. In the absence of a quorum, the Chairperson(s) may elect to designate available SSA Management staff or SSA's who are not directly involved with the individual's plan, or poll members for verbal approval, until their signatures can be obtained.
    c. All information and documents provided to the HRC and all discussions of the committee shall be confidential and shall not be shared or discussed with anyone other than the individual and his or her guardian and the individual's team.
3. **Restrictive Measures Approval**:
    a. Approval of a restrictive measure requires the affirmative vote of a majority of the members present. In the event that a majority is unable to be reached due to an even number of votes, the HRC Chairperson(s) determines whether or not the plan is approved.
    b. Dissenting opinions are documented.
4. **Emergency HRC Approval and Extension Requests:**
    a. If a restrictive measure requires emergency approval, the HRC Chairperson(s) may secure the approval, via email or phone, or signature, of three other committee members until full committee review and approval can be accomplished.
    b. The implementation date of a restrictive measure may be extended for a maximum of 30 days, if the plan is in the active process of being revised or approved. To request an extension the SSA submits a "Request for HRC Extension or Emergency Approval" form to the SSA Supervisor, Behavior Support Unit. The Supervisor and HRC Chairperson(s) review the form noting whether the extension is being granted. A second and final 30-day extension can be granted only when approved by quorum at an HRC meeting.
5. **Roles and Responsibilities:**
    The HRC shall review, approve or reject, monitor, and reauthorize strategies that include restrictive measures. In this role, the HRC shall:
    a. Ensure that the planning process outlined in 5123:2-2-06 has been followed and that the individual or the individual's guardian, as applicable, has provided informed consent and been afforded due process;
    b. Ensure that the proposed restrictive measures are necessary to reduce risk of harm or likelihood of legal sanction;
    c. Ensure that the overall outcome of the behavioral support strategy promotes the physical, emotional, and psychological wellbeing of the individual while reducing risk of harm or likelihood of legal sanction;

d. Ensure that a restrictive measure is temporary in nature and occurs only in specifically defined situations based on risk of harm or likelihood of legal sanction;
e. Verify that any behavioral support strategy that includes restrictive measures also incorporates actions designed to enable the individual to feel safe, respected, and valued while emphasizing choice, self-determination, and an improved quality of life; and
f. Communicate the committee's determination in writing to the SSA submitting the request for approval.

6. **Use of a Restrictive Measure Without Prior Approval by the HRC**:
   a. Use of a restrictive measure, including use of a restrictive measure in a crisis situation (e.g., to prevent an individual from running into traffic), without prior approval by the HRC shall be reported as "unapproved behavior support" in accordance with rule 5123:2-17-02 of the Administrative Code.
   b. Nothing in these procedures shall be construed to prohibit or prevent any person from intervening in a crisis situation as necessary to ensure a person's immediate health and safety.

D. **Restrictive Measure Notifications**: After securing approval by the HRC and prior to implementation of a behavioral support strategy that includes restrictive measures, SCBDD shall notify the department in a format prescribed by the department of each HRC approved restrictive measure. Upon request by the Ohio Department of Developmental Disabilities (DODD), SCBDD shall submit any additional information regarding the use of restrictive measures.

E. **Reviews**: The SSA ensures the strategy is reviewed by the individual and the team at least every ninety days, or more often as determined by the interdisciplinary team, to determine and document the effectiveness of the strategy and whether the strategy should be continued, discontinued, or revised. A decision to continue the strategy shall be based upon review of up-to-date information which indicates risk of harm or likelihood of legal sanction is still present. Reviews are documented by status reports to include a narrative regarding progress, any significant events, and a comparison of current data to baseline data. Written status reports are forwarded to all team members at least every ninety days. Providers implementing approved restrictive measures must submit requested monthly data to the SSA by the 5th day of each following month. When data has not been received for three consecutive months, for an ISP that includes restrictive measures, the use of the restrictive measures will be discontinued in the environment from which data was not received.

F. **Recording Use of Restrictive Measures** - Each provider shall maintain a record of the date, time, duration, and antecedent factors regarding each use of a restrictive measure other than a restrictive measure that is not based on antecedent factors (e.g., bed alarm or locked cabinet). The provider shall share the record with the individual and the

individual's team whenever the individual's behavioral support strategy is being reviewed or reconsidered.

G. **Analysis of Strategies that Include Restrictive Measures** - SCBDD shall compile and analyze data regarding behavioral support strategies that include restrictive measures and furnish the data and analyses to the HRC and to DODD upon request. Data compiled and analyzed shall include, but are not limited to:
   1. Nature and frequency of risk of harm or likelihood of legal sanction that triggered development of strategies that include restrictive measures;
   2. Nature and number of strategies reviewed, approved, rejected, and reauthorized by the HRC;
   3. Nature and number of restrictive measures implemented;
   4. Duration of strategies that include restrictive measures implemented; and
   5. Effectiveness of strategies that include restrictive measures in terms of increasing or decreasing behaviors as intended.

H. **Changes and Discontinuations**:
   1. **Adding Positive Interventions or Reducing Restrictive Measures –** Adding positive interventions or making changes that render an ISP less restrictive, while utilizing the same intervention (e.g., a decrease in the maximum length of manual restraint) are documented on the monthly status report and implemented through an update to the ISP. HRC approval is not needed when reducing restrictive measures.
   2. **Changing or Adding Restrictive Measures –** Changes to the type of intervention (e.g., replacing manual restraint with time-out) or utilization of a more restrictive intervention (e.g., an increase in the maximum length of manual restraint) require an updated ISP and HRC approval.
   3. **Discontinuations** - Any restrictive measure that has not been utilized for 12 months will be formally discontinued and will not be implemented again unless evidence develops that the intervention, once again, is necessary and is the least restrictive option.

I. **Emergency Interventions during Crisis Situations:**
   1. **Crisis Situations:**
      a. A clear and present danger to others exists (i.e., an individual is physically acting out in ways that seem likely to cause bodily harm to others), or
      b. A clear and present danger to self exists (i.e., an individual is self-abusing in a way that seems likely to cause bodily harm).
   2. **Crisis Management:**
      a. The process of protecting an individual or others from harm when there is no approved restrictive measure in place.
      b. When a “crisis” behavior occurs more than once per week, more than three times per month, or more than six times per year, a restrictive measure must

be developed to address the behavior(s). The behavior(s) are then no longer considered a crisis.

c. A behavior does not need to meet/exceed the crisis management criteria for the team to determine that a restrictive measure is needed.

3. **Crisis Intervention Strategies** – In order to deal with a crisis situation in an effective and humane manner, a hierarchy of techniques beginning with the least intrusive is used. The hierarchy includes:
   a. **Alteration of the environment** – moving materials, objects, furniture, people, etc. to minimize the risk of harm and/or end the behavior.
   b. **Non-physical interventions** – strategies for de-escalation may include, but are not limited to, establishing rapport (e.g., by addressing the individual by name), using diversion or distraction, channeling the individual's feelings into positive activities (e.g., walking, relaxation techniques), engaging in side-dialogue or cross-dialogue with others, using reflective listening or paraphrasing, offering the individual options and choices, problem solving, accompanying the individual to a calmer setting, and setting limits.
   c. **Manual restraint** – (See section II.C.6.a.)
4. **Emergency Relocation of Services** – An individual may have his/her services relocated to another setting, but he/she may not be suspended from services without being provided information about due process, Resolution of Complaints Procedure or Medicaid Appeal rights. See SCBDD Policy 5.15 for guidelines related to suspensions and emergency removals for adults receiving services.
5. **Reporting of Crisis Events** – All incidents involving the use of manual restraint or any restrictive measure or intervention implemented without prior approval by the HRC, and/or without informed consent, must be reported as an MUI.