Minnesota Department of **Human Services**

Rule 40 Advisory Committee Meeting
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June 4, 2012, 9:00-3:30
444 Lafayette Road, Room 3148

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Minnesota Department of Human Services

Rule 40 Advisory Committee
Lafayette Building, Room 3148
June 4, 2012 Agenda

I. Opening (9:00-9:15) — Gail Dekker
   A. Welcome and intros
   B. Agenda review (Handout #1)

II. Person-Centered Thinking & Positive Behavior Supports (9:15-10:45) — Rick Amado & Tim Moore
   Presentation, questions, discussion (Handouts #2-12)

III. Break (10:45-11:00)

IV. Person-Centered Thinking & Positive Behavior Supports (11:00-12:00) — Group
   Building a decision

V. Lunch (12:00-12:45)

VI. Discussion: (12:45-2:00) — Group
   Continue PCT and PBS discussion, as needed.
   Return to Prohibitions and Emergency Use of Restraints, as time permits

VII. Break (2:00-2:15)

VIII. Discussion (2:15-3:00) — Group
   Continue prior discussion, if needed
   Begin discussion of monitoring, reporting, and oversight

IX. Updates (3:00-3:10)
   A. Provider survey — Dean Ritzman
   B. Department of Education (Handout #13) — Barbara Case

X. Closing (3:10-3:30) — Gail Dekker
   A. Next meeting
      1. Scheduled for Monday, July 9, 9:00- 3:30 In Lafayette 3148
      2. Your suggestions for next meeting's agenda?

   B. Meeting evaluation: What worked well today? What didn't work well? What would you change to improve future meetings?

   C. Final questions?
   D. Thanks! And Adjourn

February 2007: Iteration I

APBS

PBS STANDARDS OF PRACTICE: INDIVIDUAL LEVEL

This document is a collaborative effort of the membership and the Board of the Association for Positive Behavior Supports (APBS). It is a "work in progress" with the intent of identifying those concepts and methods essential to the implementation of positive behavior supports (PBS) on the individual level; that is, with individuals who engage in problem behavior. This document includes many items that reflect the foundations of Applied Behavior Analysis (ABA), although it is certainly not comprehensive in this regard. We feel inclusion of these items is important, as ABA is an integral part of PBS. But it also includes additional concepts and methods that will help us further define the uniqueness of PBS. We expect this document to evolve, and for us to continue to better identify and share the essence of PBS. Areas for further development and articulation in future iterations of this document include (but are not limited to): person-centered decision-making, quality of life outcomes, the commitment to constructive and socially acceptable strategies, and incorporation of concepts and methods derived from a variety of sciences and disciplines (e.g., organizational management, ecological psychology, biomedical science). Please consider these thoughts as you review Iteration I of the APBS Standards of Practice: Individual Level.

I. Foundations of PBS

A. Practitioners of PBS have an historical perspective on the evolution of PBS and its relationship to ABA and movements in the disability field

1. History of applied behavior analysis and the relationship to PBS
2. Similarities and unique features of PBS and ABA
3. Movements in the field of serving persons with disabilities that influenced the emergence of PBS practices
    a. Deinstitutionalization
    b. Normalization and social role valorization
    c. Community participation
    d. Supported employment
    e. Least restrictive environment and inclusive schooling
    f. Self-determination

B. Practitioners applying PBS with individuals adhere to a number of basic assumptions about behavior

1. Problem behavior serves a function
2. Positive strategies are effective in addressing the most challenging behavior
3. When positive behavior intervention strategies fail, additional functional assessment strategies are required to develop more effective PBS strategies
4. Features of the environmental context affect behavior
5. Reduction of problem behavior is an important, but not the sole, outcome of successful intervention; effective PBS results in improvements in quality of life, acquisition of valued skills, and access to valued activities

C. *Practitioners applying PBS with individuals include at least 11 key elements in the development of PBS supports*

1. Collaborative team-based decision-making
2. Person-centered decision-making
3. Self-determination
4. Functional assessment of behavior and functionally-derived interventions
5. Identification of outcomes that enhance quality of life and are valued by the individual, their families and the community
6. Strategies that are acceptable in inclusive community settings
7. Strategies that teach useful and valued skills
8. Strategies that are evidence-based, and socially and empirically valid to achieve desired outcomes that are at least as effective and efficient as the problem behavior
9. Techniques that do not cause pain or humiliation or deprive the individual of basic needs
10. Constructive and respectful multi-component intervention plans that emphasize antecedent interventions, instruction in prosocial behaviors, and environmental modification
11. On-going measurement of impact

D. *Practitioners applying PBS with individuals commit themselves to ongoing and rigorous professional development*

1. Pursue continuing education and inservice training as well as consulting peer reviewed journals and current publications to stay abreast of emerging research, trends and national models of support
2. Attend national, regional, state and local conferences
3. Seek out collaboration, support and/or assistance when faced with challenges outside of one's expertise
4. Seek out collaboration, support and/or assistance when intended outcomes are not achieved in a timely
5. Seek out knowledge from a variety of empirically-based fields relevant to the people whom they serve. These fields include education, behavioral and social sciences, and the biomedical sciences

E. *Practitioners of PBS understand the legal and regulatory requirements related to assessment and intervention regarding challenging behavior and behavior change strategies.*

1. Requirements of IDEA with respect to PBS
2. The purpose of human rights and other oversight committees regarding behavior change
3. Works within state/school/agency regulations and requirements

(2007). *PBS standards of practice: Individual level*. Available for download from http://apbs.org/whatsnew.html#standards_of_practice.

II. Collaboration and Team Building

A. Practitioners of PBS understand the importance of and use strategies to work collaboratively with other professionals, individuals with disabilities, and their families

1. Understands and respects the importance of collaboration in providing effective PBS services
2. Uses skills needed for successful collaboration, including the ability to:
   a. Communicate clearly
   b. Establish rapport
   c. Be flexible and open
   d. Support the viewpoints of others
   e. Learn from others
   f. Incorporate new ideas within personal framework
   g. Manage conflict

B. Practitioners of PBS understand the importance of and use strategies to support development and effectiveness of collaborative teams

1. Includes the critical members of a PBS team for the individual considering the age, setting, and types of abilities and disabilities of the individual
2. Evaluates team composition considering the needs of the individual and assists the team in recruiting additional team members to address needed areas of expertise
3. Uses essential team skills, including:
   a. Facilitation
   b. Coaching
   c. Mediation
   d. Consensus building
   e. Meeting management
   f. Team roles and responsibilities
4. Uses strategies and processes to demonstrate sensitivity to and respect for all team members, and diverse opinions and perspectives
5. Facilitates the inclusion of and respect for the values and priorities of families and all team members
6. Supports and participates in advocacy necessary to access supports to carry out team decisions

III. Basic Principles of Behavior

A. Practitioners of PBS utilize behavioral assessment and support methods that are based on operant learning

1. The antecedent-behavior-consequence model as the basis for all voluntary behavior
2. Operational definitions of behavior
3. Stimulus control, including discriminative stimuli and S-deltas
4. The influence of setting events (or establishing operations), on behavior
5. Antecedent influences on behavior
6. Precursor behaviors

(2007). *PBS standards of practice: Individual level*. Available for download from http://apbs.org/whatsnew.html#standards_of_practice.

7. Consequences to increase or decrease behavior

B. Practitioners of PBS understand and use antecedent manipulations to influence behavior, such as:

1. Curricular modifications
2. Instructional modifications
3. Behavioral precursors as signals
4. Modification of routines
5. Opportunities for choice/control throughout the day
6. Clear expectations
7. Pre-correction
8. Errorless learning

C. Practitioners of PBS understand and use consequence manipulations to increase behavior

1. Primary reinforcers, and conditions under which primary reinforcers are used
2. Types of secondary reinforcers and their use
3. Approaches to identify effective reinforcers, including:
   a. Functional assessment data
   b. Observation
   c. Reinforcer surveys
   d. Reinforcer sampling
4. Premack principle
5. Positive reinforcement
6. Negative reinforcement
7. Ratio, interval, and natural schedules of reinforcement
8. Pairing of reinforcers

D. Practitioners of PBS understand consequence manipulations to decrease behavior

1. The use of punishment, including characteristics, ethical use of punishment, and potential side effects of punishment procedures. *(Any use of punishment, including strategies that are found within integrated natural settings, must be within the parameters of the 11 key elements Identified above in IC, with particular attention to IC9 "techniques that do not cause pain or humiliation or deprive the individual of basic needs;"*
2. Differential reinforcement, including:
   a. Differential reinforcement of alternative behavior
   b. Differential reinforcement of incompatible behavior
   c. Differential reinforcement of zero rates of behavior
   d. Differential reinforcement of lower rates of behavior
3. Extinction, including:
   a. Characteristics of extinction interventions
   b. How to use extinction
   c. Using extinction in combination with interventions to develop replacement behaviors
4. Response cost, including:
   a. Cautions associated with use of response cost.

(2007). *PBS standards of practice: Individual level*. Available for download from http://apbs.org/whatsnew.html#standards_of_practice.

   b. Using response cost with interventions to develop replacement behaviors.
5. Timeout, including:
   a. Types of timeout applications
   b. How to implement
   c. Cautions associated with use of timeout
   d. Using timeout with interventions to develop replacement behaviors

E. Practitioners of PBS understand and use methods for facilitating generalization and maintenance of skills

1. Forms of generalization, including:
   a. Stimulus generalization
   b. Response generalization
   c. Generalization across subjects
2. Maintenance of behaviors across time.

IV. Data-Based Decision-Making

A. Practitioners of PBS understand that data-based decision-making is a fundamental element of PBS, and that behavioral assessment and support planning begins with defining behavior.

1. Using operational definitions to describe target behaviors
2. Writing behavioral objectives that include:
   a. Conditions under which the behavior should occur
   b. Operational definition of behavior
   c. Criteria for achieving the objective

B. Practitioners of PBS understand that data-based decision-making is a fundamental element of PBS, and that measuring behavior is a critical component of behavioral assessment and support

1. Using data systems that are appropriate for target behaviors, including:
   a. Frequency
   b. Duration
   c. Latency
   d. Interval recording
   e. Time sampling
   f. Permanent product recording
2. Developing data collection plans that include:
   a. The measurement system to be used
   b. Schedule for measuring behavior during relevant times and contexts, including baseline data
   c. Manageable strategies for sampling behavior for measurement purposes
   d. How, when, and if the inter-observer agreement checks will be conducted
   e. How and when procedural integrity checks will be conducted
   f. Data collection recording forms
   g. How raw data will be converted to a standardized format (e.g. rate, percent)

(2007). *PBS standards of practice: Individual level*. Available for download from http://apbs.org/whatsnew.html#standards_of_practice.

h. Use of criterion to determine when to make changes in the instructional phase

C. Practitioners of PBS use graphic displays of data to support decision making during the assessment, program development, and evaluation stages of behavior support.

1. Converting raw data in standardized format
2. Following graphing conventions, including:
   a. Clearly labeled axes
   b. Increment scales that allow for meaningful and accurate
3. Representation of the data
   a. Phase change lines
   b. Clearly labeled phase change descriptions
   c. Criterion lines

D. Practitioners of PBS use data-based strategies to monitor progress

1. Using graphed data to identify trends and intervention effects
2. Evaluating data regularly and frequently
3. Sharing data with team members for team-based, person-centered, decision-making
4. Using data to make decisions regarding program revisions to maintain or improve behavioral progress, including decisions relating to maintaining, modifying, or terminating interventions
5. Using data to determine if additional collaborations, support and/or assistance is needed to achieve intended outcomes

V. Comprehensive Person Centered and Functional Behavior Assessments

A. Practitioners understand the importance of multi-element assessments including:

1. Person Centered Planning
2. Quality of Life
3. Environmental/ecology
4. Setting events
5. Antecedents and consequences
6. Social Skills/Communication/Social Networks
7. Curricular/instructional needs (e.g., learning style)
8. Health/biophysical

B. Comprehensive assessments result in information about the focus individual in at least the following areas:

1. Lifestyle
2. Preferences and interests
3. Communication/social abilities & needs
4. Ecology
5. Health and safety
6. Problem routines

(2007). *PBS standards of practice: Individual level*. Available for download from http://apbs.org/whatsnew.html#standards_of_practice.

7. Variables promoting and reinforcing problem behavior:
   a. Preferences/reinforcers
   b. Antecedents
   c. Setting events
   d. Potential replacement behavior
8. Function(s) of behavior
9. Potential replacement behaviors

C. Practitioners who apply PBS conduct Person Centered Assessments that provide a picture of the life of the individual including:

1. Indicators of quality of life comparable to same age individuals without disabilities (e.g., self determination, inclusion, friends, fun, variety, access to belongings)
2. The strengths and gifts of the individual
3. The variety and roles of persons with whom they interact (e.g., family, friends, neighbors, support providers) and the nature, frequency and duration of such interactions.
4. The environments & activities in which they spend time including the level of acceptance and meaningful participation, problematic and successful routines, preferred settings/activities, the rate of reinforcement and/or corrective feedback, and the age appropriateness of settings, activities & materials.
5. The level of independence and support needs of the individual including workplace, curricular & instructional modifications, augmentative communication and other assistive technology supports, and assistance with personal management and hygiene
6. The health and medical/biophysical needs of the individual
7. The dreams & goals of the individual & their circle of support.
8. Barriers to achieving the dreams & goals.
9. The influence of the above information on problem behavior.

D. PBS practitioners conduct Functional Behavioral Assessments that result in:

1. Operationally defined problem behavior
2. The context in which problem behavior occurs most often
3. Identification of setting events that promote the potential for problem behavior
4. Identification of antecedents that set the occasion for problem behavior
5. Identification of consequences maintaining problem behavior
6. A thorough description of the antecedent-behavior-consequence relationship
7. An interpretation of the function(s) of behavior
8. Identification of potential replacement behavior

E. PBS practitioners conduct indirect and direct assessment strategies

1. Indirect assessments include file reviews, structured interviews (e.g., person centered planning), checklists, and rating scales (e.g., MAS)
2. Direct assessments include such strategies as scatterplots, anecdotal recording, A-B-C data, and time/activity analyses
3. Summarize data in graphic and narrative formats

F. PBS practitioners work collaboratively with the team to develop hypotheses that are supported by assessment data

1. All assessment information is synthesized and analyzed to determine the possible influence of the following on the occurrence or non-occurrence of problem behavior:

a. setting events (or establishing operations)
b. antecedents/triggers
c. consequences for both desired and challenging behaviors
d. ecological variables
e. lifestyle issues
f. medical/biophysical problems

2. Hypotheses statements are developed that address:
   a. setting events
   b. antecedents
   c. consequences for both desired and challenging behaviors
   d. function(s) problem behavior serves for the individual

G. PBS practitioners utilize Functional Analysis of Behavior as necessary on the basis of an understanding of:

1. The differences between functional assessment and functional analysis
2. The advantages & disadvantages of functional analysis
3. The conditions under which each approach may be conducted

VI. Development and Implementation of Comprehensive, Multi-element Behavior Support Plans

A. PBS practitioners apply the following considerations/foundations across all elements of a PBS plan

1. Behavior support plans are developed in collaboration with the individual and his or her team
2. Behavior support plans are driven by the results of person centered and functional behavior assessments
3. Behavior support plans facilitate the individual's preferred lifestyle
4. Behavior support plans are designed for contextual fit, specifically in relation to:
   a. The values and goals of the team
   b. The current and desired routines within the various settings in which the individual participates
   c. The skills and buy-in of those who will be implementing the plan
   d. Administrative support
5. Behavior support plans include strategies for evaluating each component plan of the plan

B. Behavior Support Plans include interventions to improve/support Quality of Life in at least the following areas:

1. Achieving the individual's dreams
2. The individual's health and physiological needs
3. Promote all aspects of self determination
4. Improvement in individual's active, successful participation in inclusive school, work, home and community settings
5. Promotion of social interactions, relationships, and enhanced social networks
6. Increased fun and success in the individual's life
7. Improved leisure, relaxation, and recreational activities for the individual

throughout the day

C. PBS practitioners develop behavior support plans that include antecedent interventions to prevent the need for problem behavior using the following strategies:

1. Alter or eliminate setting events to preclude the need for problem behavior
2. Modify specific antecedent triggers/circumstances based on the FBA
3. Identify and address behaviors using precursors (i.e. individual's signal that a problem behavior is likely to occur)
4. Make the individual's environment/routines predictable (e.g., personal schedule in format the individual can understand)
5. Build opportunities for choice/control throughout the day that are age-appropriate and contextually appropriate
6. Create clear expectations
7. Modify curriculum/job demands so the individual can successfully complete tasks

D. PBS plans address effective instructional intervention strategies that may include the following:

1. Match instructional strategies to the individual's learning style
2. Provide instruction in the context in which the problem behaviors occur and the use of alternative skills, including instruction in skills such as:
   a. Communication skills
   b. Social skills
   c. Self-management/monitoring skills
   d. Other adaptive behaviors as indicated by the FBA and continued evaluation of progress data (e.g., relaxation techniques)
3. Teach replacement behavior(s) based on competing behavior analysis
4. Select and teach replacement behaviors that can be as or more effective than the problem behavior
5. Utilize instructional methods of addressing a problem behavior proactively (including pre-instruction; modeling; rehearsal; social stories; incidental teaching; use of peer buddies; meeting sensory needs; direct instruction; verbal, physical, and/or visual prompting)

E. PBS practitioners employ consequence intervention strategies that consider the following:

1. Reinforcement strategies are function based and rely on naturally occurring reinforcers as much as possible.
2. Use the least intrusive behavior reduction strategy (e.g., error correction, extinction, differential reinforcement)
3. Emergency intervention strategies are used only where safety of the individual or others must be assured
4. Plans for avoiding power struggles and provocation
5. Plan for potential natural consequences. Consider when these should happen and when there should be attempts to avoid them. Although some natural consequences are helpful to the individual (e.g., losing money, missing a bus), others can be detrimental and provide no meaningful experience (e.g., being hit by a car, admission to psychiatric unit).

F. PBS practitioners develop plans for successful implementation of positive behavior support plans that include:

1. Action plans for implementation of all components of the intervention including:
   a. Activities, dates and documentation describing who is responsible for completing each task
   b. Materials, training and support needed for those doing intervention
   c. How data will be collected and analyzed to address both impact and fidelity of intervention
   d. Timelines for meetings, data analysis and targeted outcomes
   e. Training, supports and time needed for plan implementation
   f. Criteria for team meetings for immediate modification of PBS plan
   g. Plans for review of contextual fit. function based interventions, and lifestyle enhancements
2. Strategies to address systems change needed for implementation of PBS plans that may include:
   a. Modifying policies/regulations
   b. Support and training for personnel & families
   c. Accessing needed resources (financial & personnel)
   d. Increasing flexibility in routines, & staffing schedules
   e. Recruiting additional individuals to be team members (e.g. bus driver, peers, neighbors, extended family
   f. Interagency collaboration

G. PBS Practitioners evaluate plan implementation and use data to make needed modifications

1. Implement plan, evaluate and monitor progress according to timelines
2. Collect data identified for each component of PBS plan
3. Analyze data on regular basis to determine needed adjustments
4. Evaluate progress on Person Centered Plans (e.g. quality of life, social networks, personal preferences, upcoming transitions)
5. Modify each element of the PBS plan as indicated by evaluation data

Standards Committee Chairs:

Jacki Anderson, Fredda Brown, Brenda Scheurmann

(2007). *PBS standards of practice: Individual level*. Available for download from http://apbs.org/whatsnew.html#standards_of_practice.

Positive Behavior Support : Evolution of an Applied Science

Edward G. Carr, Glen Dunlap, Robert H. Horner, Robert L. Koegel, Ann P. Turnbull, Wayne Sailor, Jacki L. Anderson, Richard W. Albin, Lynn Kern Koegel and Lise Fox

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Positive Behavior Support:

Evolution of an Applied Science

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Abstract: Positive behavior support (PBS) is an applied science that uses educational and systems change methods (environmental redesign) to enhance quality of life and minimize problem behavior. PBS initially evolved within the field of developmental disabilities and emerged from three major sources: applied behavior analysis, the normalization/inclusion movement, and person-centered values. Although elements of PBS can be found in other approaches, its uniqueness lies in the fact that it integrates the following critical features into a cohesive whole: comprehensive lifestyle change, a lifespan perspective, ecological validity, stakeholder participation, social validity, systems change and multicomponent intervention, emphasis on prevention, flexibility in scientific practices, and multiple theoretical perspectives. These characteristics are likely to produce future evolution of PBS with respect to assessment practices, intervention strategies, training, and extension to new populations. The approach reflects a more general trend in the social sciences and education away from pathology-based models to a new positive model that stresses personal competence and environmental integrity.

The fourfold purpose of this article is to (a) provide a definition of the evolving applied science of positive behavior support (PBS); (b) describe the background sources from which PBS has emerged; (c) give an overview of the critical features that, collectively, differentiate PBS from other approaches; and (d) articulate a vision for the future of PBS.

Definition

PBS is an applied science that uses educational methods to expand an individual's behavior repertoire and systems change methods to redesign an individual's living environment to first enhance the individual's quality of life and, second, to minimize his or her problem behavior (Carr, Horner, et al., 1999; Koegel, Koegel, & Dunlap, 1996). *Positive behavior* includes all those skills that increase the likelihood of success and personal satisfaction in normative academic, work, social, recreational, community, and family settings. Support encompasses all those educational methods that can be used to teach, strengthen, and expand positive behavior and all those systems change methods that can be used to increase opportunities for the display of

positive behavior. The primary goal of PBS is to help an individual change his or her lifestyle in a direction that gives all relevant stakeholders (e.g., teachers, employers, parents, friends, and the target person him- or herself) the opportunity to perceive and to enjoy an improved quality of life. An important but secondary goal of PBS is to render problem behavior irrelevant, inefficient, and ineffective by helping an individual achieve his or her goals in a socially acceptable manner, thus reducing, or eliminating altogether, episodes of problem behavior.

Background Sources Related to Philosophy and Practice

PBS emerged from three major sources: (a) applied behavior analysis, (b) the normalization/inclusion movement, and (c) person-centered values.

APPLIED BEHAVIOR ANALYSIS

Applied behavior analysis is the systematic extension of the principles of operant psychology to problems and issues of social importance (Baer, Wolf, & Risley, 1968). Were it not for the past 35 years of research in applied behavior analysis, PBS could not have come into existence. Applied behavior analysis has made two major contributions to PBS. First, it has provided one element of a conceptual framework relevant to behavior change. Second, and equally important, it has provided a number of assessment and intervention strategies.

PBS is indebted to applied behavior analysis for the notion of the three-term contingency (stimulus-response-reinforcing consequence), the concepts of setting event and establishing operations, and the notions of stimulus control, generalization, and maintenance (Chance, 1998; Miltenberger, 1997). These and other concepts have served as a critical springboard for the elaboration and development of PBS.

Functional analysis, an assessment strategy that originated in applied behavior analysis, is an experimental method for determining the motivation (purpose) of a variety of socially significant behaviors, thereby facilitating intervention planning designed to change behavior in a desirable direction (Carr, 1977; Iwata, Dorsey, Slifer, Bauman, & Richman, 1982). The detailed elaboration of empirical methodologies, emphasizing the ongoing, direct measurement of behavior, is one of the enduring contributions of applied behavior analysis.

Applied behavior analysis helped develop educational methods such as shaping, fading, chaining, prompting, and reinforcement contingencies as well as a wide array of procedures for reducing problem behavior (Sulzer-Azaroff & Mayer, 1991). PBS has not only incorporated the elements of applied behavior analysis just described; it has also evolved beyond the parent discipline to assume its own identity. This identity is strongly influenced by the realities of conducting research and intervention in natural community settings that necessitate changes in assessment methods, intervention strategies, and the definition of what constitutes a successful outcome (Carr, 1997). These themes are an important focus of this article.

NORMALIZATION/INCLUSION MOVEMENT

Philosophically, PBS subscribes to the principle and ideal of normalization, namely, that people with disabilities should live in the same settings as others and have access to the same opportunities as others (in terms of home, school, work, recreation, and social life). The principle of normalization rests, most critically, on the idea of social role valorization, namely, that the ultimate goal is to ensure that people who are in danger of being devalued are helped to assume valued social roles, thereby increasing the likelihood that they will be accorded respect from others and will receive an equitable share of existing resources (Wolfensberger, 1983).

The normalization principle leads naturally to the principle of inclusion. During the past 150 years, the United States has been characterized by an ever-increasing emphasis on the extension of individual rights to formally disenfranchised groups, thereby facilitating the inclusion of those groups in mainstream society. The upward inclusion trajectory began with the women's suffrage/women's rights movement that occurred from 1848 through 1920 (Buechler, 1990), continued with the civil rights movement of the late 1950s and early 1960s (Solomon, 1989), and has most recently focused on the movement emphasizing the rights of individuals with disabilities that evolved during the 1970s and 1980s (Gilhool, 1989). The inclusion movement for people with disabilities continues to this day. In the educational arena, it embodies the trend toward placing students with disabilities in general education classrooms (Bricker, 1995) as opposed to segregated, special education facilities and, most significantly, changing systems so that specialized school support becomes fully integrated and coordinated with the general education program in neighborhood schools (Sailor, 1996). Inclusion in normalized settings extends beyond education. For example, in the vocational sphere, it involves replacing sheltered workshops with supported employment. Inclusion also involves replacing group homes and other congregate facilities with supported living arrangements (in which one chooses one's housemates and the neighborhood in which one wishes to live) and replacing artificial social and recreational opportunities (e.g., social groups for people with disabilities) with those emphasizing participation with people who may not have disabilities (e.g., membership in religious groups, community gyms, and social and ethnic clubs).

PERSON-CENTERED VALUES

The PBS philosophy embraces the idea that while humanistic values should not replace empiricism, these values should inform empiricism. Science tells us *how* we can change things, but values tell us *what* is worth changing (Carr, 1996). Guided by this precept, PBS represents a melding of values and technology in that strategies are judged not only with respect to efficacy (a technological criterion) but also with respect to their ability to enhance personal dignity and opportunities for choice (a values criterion). Thus, the approach eschews the use of strategies that members of the community judge to be dehumanizing or degrading (Horner et al., 1990).

Three interrelated processes serve as the vehicle for implementing the values perspective just described: person-centered planning, self-determination, and the wraparound approach.

Person-centered planning (Kincaid, 1996; O'Brien, Mount, & O'Brien, 1991; Smull & Harrison, 1992; Vandercook, York, & Forest, 1989) is a process for identifying goals and implementing intervention plans. It stands in sharp contrast to traditional program-centered planning, in which individuals with disabilities are provided with those preexisting services that a particular agency or institution has available. In person-centered planning, the specific needs and goals of the individual drive the creation of new service matrices that are carefully tailored to address the unique characteristics of the individual. Specific individual needs are considered within the context of normalization and inclusion, alluded to earlier, to produce an intervention plan that emphasizes community participation, meaningful social relationships, enhanced opportunities for choice, creation of roles that engender respect from others, and continued development of personal competencies.

Because person-centered planning seeks to empower individuals with disabilities, it almost invariably leads to a focus on the issue of *self-determination*. Self-determination is a multidimensional construct that includes but is not limited to process elements involving choice and decision making, problem solving, personal goal setting, self-management, self-instruction, and self-advocacy (Wehmeyer, 1999; Wehmeyer, Kelchner, & Richards, 1996). People with disabilities are often told what they can do, with whom they can do it, and where, when, and how they can do it. In contrast, enhancing the process of self-determination involves changing systems and redesigning environments with a view to minimizing external (often coercive) influences and making the person with disabilities the primary causal agent in his or her own life. The end point of this process can be an enhancement of lifestyle with respect to employment, living situation, friendships, and personal satisfaction (Bambara, Cole, & Koger, 1998; Wehmeyer & Schwartz, 1997). These outcomes represent some of the defining features of PBS discussed later in this article.

Recently, discussion in the literature has concerned the rapidly accelerating convergence between the core philosophy and methods represented by PBS and a process referred to as *wraparound* (Clark & Hieneman, 1999). Wraparound incorporates person-centered planning in its emphasis on developing support plans that are needs-driven rather than service-driven. Ultimately, such planning has an impact on the entire family system. The approach is buttressed by flexible, noncategorical funding. Wraparound also incorporates a self-determination philosophy in its reliance on a support team whose membership is balanced between experts on the one hand and the individual with disabilities, family members, and advocates on the other, all of whom help identify and act on the individual's needs with a view to empowering that individual (Eber, 1997; VanDenBerg & Grealish, 1998). It reflects person-centered values in its emphasis on assessing strengths rather than deficits and problems. The approach focuses on meeting a person's needs in critical life domain areas such as family, living situation, financial, educational/vocational, social/recreational, behavioral/emotional, psychological, health, legal, cultural, and safety (VanDenBerg & Grealish, 1998). The guiding hypothesis is that if an individual's needs are met, then quality of life will improve, and problem behavior will be reduced or eliminated altogether. This hypothesis, of course, is also one of the defining assumptions behind positive behavior support.

Critical Features

The background sources related to the philosophy and practice of PBS have helped create an evolving applied science whose critical features, collectively, differentiate it from other approaches. As noted, some of these features can be found in other approaches as well and have been scattered throughout the literature of the past 15 years. However, what makes PBS unique is its emphasis on integrating, into a cohesive whole, the nine characteristics described next.

COMPREHENSIVE LIFESTYLE CHANGE AND QUALITY OF LIFE

The sine qua non of PBS is its focus on assisting individuals to achieve comprehensive lifestyle change with a view to improving quality of life not only for persons with disabilities but also for those who support them. When applied to larger organizational units such as schools (Sugai et al., 2000), the focus of PBS is on assisting the unit to achieve broad changes that facilitate more positive outcomes for all participants. In this light, the reduction of challenging be-

haviors per se is viewed as an important secondary goal that is of value principally because of its facilitative effect on producing meaningful lifestyle and cultural changes that are stable and enduring.

A truly comprehensive approach to lifestyle change addresses the multiple dimensions that define quality of life (Hughes, Hwang, Kim, Eisenman, & Killian, 1995), which include improvements in social relationships (e.g., friendship formation), personal satisfaction (e.g., self-confidence, happiness), employment (e.g., productivity, job prestige, good job match), self-determination (e.g., personal control, choice of living arrangements, independence), recreation and leisure (e.g., adequate opportunities, good quality of activities), community adjustment (e.g., domestic skills, survival skills), and community integration (e.g., mobility, opportunities for participation in community activities, school inclusion). Although not every intervention attempted need be comprehensive, the cumulative impact of many interventions over time should be.

In sum, the definition of outcome success now emphasizes improvements in family life, jobs, community inclusion, supported living, expanding social relationships, and personal satisfaction and de-emphasizes the focus on problem behavior (Risley, 1996; Ruef, Turnbull, Turnbull, & Poston, 1999; Turnbull & Ruef, 1997). The important units of analysis concern the person's daily routines, schedules, and social interactions. Problem behavior is of note to the extent that it interferes with achieving positive results with respect to these molar variables. However, the primary intervention strategy involves rearranging the environment to enhance lifestyle and improve quality of life rather than operating directly on reducing problem behavior per se.

LIFE SPAN PERSPECTIVE

Comprehensive lifestyle change does not typically occur within a compressed time frame. Therefore, another critical feature of PBS is that it has a life span perspective. Efforts to achieve meaningful change often take years (Nickels, 1996; Turnbull & Turnbull, 1999). Successfully assisting an individual to make transitions from preschool to elementary and high school, and then to the workplace and supported living, requires a life span perspective, which views intervention as a never-ending systemic process that evolves as different challenges arise during different stages of life (Turnbull, 1988; Vandercook et al., 1989). When one follows an individual over many years in changing life circumstances, deficient environments and deficient adaptive skills will almost certainly continue to emerge and be identified. Therefore, new PBS strategies may have to be added and old ones modified. With few exceptions, most research published to date has been characterized by short-term approaches (Carr, Horner, et al., 1999). Further, maintenance has often been defined as durable success following intervention cessation (Carr et al., 1990). Yet, as noted, in a truly comprehensive PBS approach, intervention never ends and follow-up is measured in decades, not months. In sum, a life span perspective has become the new standard for maintenance, a fact that is evident in person-centered planning approaches that address the individual's needs and challenges over a period of many years (Kincaid, 1996; Turnbull & Turnbull, 1999; Vandercook et al., 1989).

The focus on comprehensive lifestyle change and life span perspective leads to three additional important features of PBS: ecological validity, stakeholder participation, and social validity.

ECOLOGICAL VALIDITY

Much previous research has focused on the microanalysis of cause-and-effect processes in analog situations, that is, on issues related to internal validity. Although it is true that there is no viable science without internal validity, it is equally true that there is no viable practice without external validity. PBS is not intended to be a laboratory-based demonstration or analog but, rather, a strategy for dealing with quality-of-life issues in natural community contexts. Although there is a continuing emphasis on issues related to internal validity, the main focus of the PBS approach concerns how applicable the science is to real-life settings, in other words, its ecological validity (Dunlap, Fox, Vaughn, Bucy, & Clarke, 1997; Meyer & Evans, 1993).

Internal validity is best demonstrated in situations in which one is able to enhance experimental control. Frequently, these situations are characterized by the involvement of atypical intervention agents such as researchers and psychologists (i.e., intervention agents who would not normally be expected to be the primary support people in community settings), working in atypical settings such as clinics and institutions, carrying out brief intervention sessions that often last only 10 to 15 minutes, in highly circumscribed venues (e.g., only one situation out of the many that may be associated with behavior challenges; Carr, Horner, et al., 1999). However, this approach is inconsistent with the PBS emphasis on normalization and inclusion in natural community contexts. Therefore, PBS entails balancing a concern with internal validity with the realities of conducting research and practice in complex naturalistic contexts in order to achieve ecological validity as well. Thus, the evolution of PBS is toward an approach that involves typical intervention agents (e.g., parents, teachers, job coaches) supporting individuals in typical settings (e.g., the home, the neighborhood, the school, the workplace) for protracted periods of time in all relevant venues (and not just those that lend themselves to good ex-

perimental control). This constellation of features defines the ecological validity dimension of PBS.

STAKEHOLDER PARTICIPATION

Traditionally, the field has embraced models of assessment and intervention that have been expert-driven rather than consumer-driven. Thus, behavior analysts, for example, have functioned as experts, defining the issues, selecting and designing interventions, and enlisting the aid of consumers (e.g., parents and teachers) in implementing strategies. The PBS approach, in contrast, has emphasized that consumers are not helpers but, rather, function as active participants and collaborators with professionals in a process of reciprocal information exchange. All members of the support team who are relevant stakeholders (e.g., parents, siblings, neighbors, teachers, job coaches, friends, roommates, and the person with disabilities) participate as partners to build the vision, methods, and success criteria pertinent to defining quality of life for everyone concerned.

This type of collaboration between professionals, researchers, and stakeholders has been called for by policymakers for many years (Lloyd, Weintraub, & Safer, 1997; Malouf & Schiller, 1995). Recently, such thinking has led to an increased emphasis on the notion of partnerships (Meyer, Park, Grenot-Scheyer, Schwartz, & Harry, 1998; Turnbull, Friesen, & Ramirez, 1998) and has produced a model that views researchers, professionals, and stakeholders as collaborators (Browder, 1997; Lawson & Sailor, in press; Nietupski, Hamre-Nietupski, Curtin, & Shrikanth, 1997; Reichle, 1997; Sailor, in press). Thus, the detailed knowledge that families have of the strengths, needs, and challenges of the person with disabilities becomes the cornerstone for collaborative planning, which yields a program of comprehensive family support (Albin, Lucyshyn, Horner, & Flannery, 1996; Lucyshyn, Albin, & Nixon, 1997; Turnbull & Turnbull, 1999; Vaughn, Dunlap, Fox, Clarke, & Bucy, 1997). Likewise, this model has been extended to other stakeholders such as job coaches and other employees at worksites (Park, Gonsier-Gerdin, Hoffman, Whaley, & Yount, 1998) as well as teachers and administrators in neighborhood schools (Salisbury, Wilson, & Palombaro, 1998).

In sum, stakeholders have evolved from a passive role in which they are instructed by an expert, to an active role in which they (a) provide valuable qualitative perspectives for assessment purposes; (b) determine whether proposed intervention strategies are relevant for all the challenging situations that need to be dealt with; (c) evaluate whether the approach taken is practical in that it meshes well (Albin et al., 1996) with the values, needs, and organizational structures related to the individual with disabilities and his or her support network; and (d) define what outcomes are likely to improve the general quality of life and enhance the individual's personal satisfaction. An egalitarian approach toward stakeholder participation has become a normative feature of PBS.

SOCIAL VALIDITY

Long ago, applied behavior analysts rejected the idea that interventions ought to be evaluated solely in terms of their objective effectiveness (Wolf, 1978). This notion has been taken up by PBS practitioners and amplified (Carr, Horner, et al., 1999). Specifically, there is an understanding that interventions should also be evaluated in terms of their practicality (e.g., Can typical support people carry out the strategy?), their desirability (e.g., Do typical support people perceive the interventions to be worthy of implementation?), their goodness of fit (e.g., Do stakeholders agree that the strategies are appropriate for the specific context in which they are to be implemented?), their subjective effectiveness with respect to problem behavior (e.g., Do the relevant stakeholders perceive that the problem behavior has been reduced to an acceptable level?), and their subjective effectiveness with respect to quality of life (e.g., Do relevant stakeholders perceive the strategies implemented to have made a meaningful difference in the lifestyle of the individual involved in terms of increasing opportunities to live, work, go to school, recreate, and socialize with typical peers and significant others in typical community settings?).

A synthesis of the experimental literature published between 1985 and 1996 (Carr, Horner, et al., 1999) indicated that these criteria for social validity have not been a prime focus for applied behavior analysis investigators until recently. Not surprisingly, then, there has been, among those committed to a PBS approach, a growing movement emphasizing the centrality of social validity in the design and implementation of service provision and remediation efforts (Dennis, Williams, Giangreco, & Cloninger, 1993; Hughes et al., 1995; Risley, 1996; Sands, Kozleski, & Goodwin, 1991; Schalock, 1990, 1996; Turnbull & Turnbull, 1999). The movement toward social validity is, of course, one logical consequence of the PBS focus on lifestyle change, life span perspective, ecological validity, and stakeholder participation already discussed.

SYSTEMS CHANGE AND MULTICOMPONENT INTERVENTION

One of the central messages of PBS is that, in providing support, we should focus our efforts on fixing problem contexts, not problem behavior. Behavior change is not simply the result of applying specific techniques to specific challenges. The best technology will fail if it is applied in an uncooperative or disorganized context. This principle has

made efforts at systems change one of the defining features of PBS.

Meaningful change is possible only if systems are restructured in a manner that enables change to occur and be sustained. It is necessary that stakeholders share a common vision, that support persons be adequately trained, that incentives be in place to motivate people to alter their approach to problem solving, that resources (temporal, physical, and human) be made available to facilitate change, and that an action plan be created that defines roles, responsibilities, monitoring, and methods to be used to correct new or ongoing deficiencies (Knoster, Villa, & Thousand, 2000).

A systemic perspective rejects the notion that practitioner effectiveness depends solely on identifying a key critical intervention that can turn the tide. For decades, applied behavior analysts have prided themselves on the publication of many successful research demonstrations that involve the application of single interventions. These demonstrations have made for great science but ineffective practice. A comprehensive approach involving multicomponent intervention is necessary to change the many facets of an individual's living context that are problematic (Horner & Carr, 1997). This conclusion was rendered inevitable by the incontrovertible evidence provided by applied behavior analysis that, for any given individual, behavior challenges are likely to be dependent on multiple functional and structural variables whose influence demands a multidimensional remediation strategy built on the assessment information (Bambara & Knoster, 1998; Carr, Carlson, Langdon, Magito McLaughlin, & Yarbrough, 1998; O'Neill et al., 1997). This multicomponent, systems change perspective is very much in evidence throughout the PBS field, whether it be in the home (Clarke, Dunlap, & Vaughn, 1999; Koegel, Koegel, Kellegrew, & Mullen, 1996; Turnbull & Turnbull, 1999), school (Sailor, 1996), workplace (Kemp & Carr, 1995), or community (Anderson, Russo, Dunlap, & Albin, 1996; Carr & Carlson, 1993; Carr, Levin, et al., 1999).

EMPHASIS ON PREVENTION

The PBS approach has helped give birth to what is, arguably, one of the greatest paradoxes in the field of developmental disabilities, namely, the notion that the best time to intervene on problem behavior is when the behavior is not occurring. Intervention takes place in the absence of problem behavior so that such behavior can be prevented from occurring again. The proactive nature of PBS stands in sharp contrast to traditional approaches, which have emphasized the use of aversive procedures that address problem behaviors with reactive, crisis-driven strategies (Carr, Robinson, & Palumbo, 1990).

The political context for the emphasis on prevention that characterizes PBS comes from legislation such as the Individuals with Disabilities Act (IDEA; 1997), which makes prevention and early intervention high priorities for professionals who deal with serious behavior challenges. This issue is part of a larger debate concerning how best to conceptualize approaches to prevention (Albee, 1996, 1998). The methodological context for the emphasis on prevention is inherent in the definition of PBS given at the beginning of this article, namely, that the approach focuses on skill building and environmental design as the two vehicles for producing desirable change.

The proactive skill-building aspect of PBS is seen, for example, in strategies that seek to prevent the recurrence of problem behavior by strengthening communicative competence (e.g., Carr & Durand, 1985) and self-management skills (e.g., Gardner, Cole, Berry, & Nowinski, 1983; Koegel, Koegel, Hurley, & Frea, 1992). The proactive environmental design aspect of PBS is seen, for example, in strategies that seek to prevent the recurrence of problem behavior by enhancing opportunities for choice making (e.g., Dunlap et al., 1994), modifying the setting events that alter the valence of reinforcers for significant behaviors (e.g., Horner, Day, & Day, 1997), and restructuring curricula (e.g., Dunlap, Kern-Dunlap, Clarke, & Robbins, 1991). Indeed, the focus on environmental design as a proactive strategy follows logically from the systems change aspect of PBS discussed earlier. Specifically, staff development, provision of incentives, resource allocation, and construction of action plans represent systemic variables whose design and implementation take place not at the moment that problem behavior is occurring but rather in a coordinated proactive fashion intended to minimize the likelihood of future episodes of problem behavior.

FLEXIBILITY WITH RESPECT TO SCIENTIFIC PRACTICES

The main tradition from which PBS emerged is applied behavior analysis. That tradition has embraced the idea that the gold standard for research methodology is the experiment and that the data of greatest import are those derived from direct observation (Baer, Wolf, & Risley, 1987). Yet, that same tradition has spawned thoughtful discussion as to whether the demonstration of causality through repeated manipulation of independent variables across time is the only acceptable methodology, or whether methods involving correlational analyses, naturalistic observations, and case studies might also produce useful and important information (Risley, 1999). Likewise, there has been a call for researchers to adopt greater flexibility in their definition of what constitutes acceptable data, moving the discussion beyond the parameters of direct observation to consider the acceptability of qualitative data, ratings, in-

terviews, questionnaires, logs, and self-report (Schwartz & Olswang, 1996).

By adhering rigidly to laboratory-based criteria of excellence, we are in danger of putting ourselves in the position of learning more and more about less and less. That is, we run the risk of addressing only those topics that readily lend themselves to our preferred investigational techniques, ignoring other topics that prove too messy or ambiguous (Kunkel, 1987; Risley, 1999). As we move our research from more controlled situations such as laboratories, clinics, and institutional settings to less controlled situations such as community-based schools, homes, and job sites, it becomes apparent that both pragmatic and validity concerns demand flexibility in scientific practices.

One pragmatic concern involves the issue of assessment. Exemplary assessment has often been equated with functional analysis, an approach involving the experimental manipulation of putatively critical variables with a view to identifying those factors responsible for controlling the behaviors of interest. Although functional analysis has proven to be a powerful and elegant tool for demonstrating causal relationships, it has most often been used by atypical intervention agents (e.g., researchers) operating in atypical settings (e.g., institutions) in highly circumscribed venues over short periods of time (Carr, Horner, et al., 1999). A recent survey of 300 practitioners noted that more informal assessment procedures, including many that are not based on direct observation, were the methods of choice; functional analysis was used by only a small minority of the study sample (Desrochers, Hile, & Williams-Moseley, 1997). Practitioners felt that an inability to control complex naturalistic variables and insufficient time to conduct elaborate assessments made functional analysis an impractical and, therefore, seldom used method in community settings. The lack of feasibility is particularly striking when one considers that the comprehensive assessment of problem behavior for even a few individuals living in the community often identifies hundreds of situations associated with diverse behavior challenges (Carr et al., 1994). A detailed functional analysis of all relevant situations would, in this case, be not just daunting but impossible. Further, conducting even a small number of functional analyses in the community is often not possible because of ethical considerations. For example, one could not manipulate variables in a supermarket in order to study the frequency with which an individual destroys property and attacks other customers.

Validity concerns arise from the issue of intervention. From a purely scientific perspective, the ideal intervention experiment is one in which a single variable is manipulated and all others are held constant. This methodology allows one to ascribe causality to the single variable being manipulated. In contrast, if several variables were to be manipulated at the same time, the experiment would be inconclusive due to confounds. There is in fact a wealth of literature demonstrating the causal impact of single interventions. While such information is useful in the initial development of a science, an exclusive reliance on pure experimentation impedes application. Specifically, in the community, one must deal with multiple interacting variables embedded in complex systems. That is why PBS intervention is almost always multicomponent in nature (e.g., Carr, Horner, et al., 1999; Horner et al., 1996; Vaughn et al., 1997). The irony is that if one adheres strictly to laboratory criteria of excellence, then what is considered to be optimal practice (multicomponent intervention) is bad science (a confounded demonstration); if one adheres strictly to pragmatic criteria of excellence, then what is considered optimal science (single variable intervention) is bad practice. A rational approach to this dilemma is to recognize that both laboratory and pragmatic criteria must be part of a truly applied science. Scientific practices must be varied and flexible enough to accommodate the analysis of pragmatic effectiveness (by studying multicomponent interventions) and the analysis of causal mechanisms and basic processes (through single variable experimentation or studies that systematically dismantle intervention packages into their components).

In sum, PBS has evolved into a science that respects the realities of conducting research in complex community settings while incorporating the fruits of research conducted within the tradition represented by formal experimentation. For this reason, PBS research methodology is flexible in encouraging correlational analyses, naturalistic observations, and case studies in addition to experiments. Likewise, the PBS definition of acceptable data includes qualitative measures, ratings, interviews, questionnaires, logs, and self-report in addition to direct observation. The type of data may vary but the expectation remains that a systematic data source will be used to evaluate and guide intervention.

MULTIPLE THEORETICAL PERSPECTIVES

As noted earlier, applied behavior analysis and its accompanying operant conceptual framework have played a major role in shaping the development of PBS. However, as PBS has continued to evolve, it has drawn, increasingly, on other theoretical perspectives as well.

The strongly interrelated fields of systems analysis, ecological psychology, environmental psychology, and community psychology have made significant contributions to PBS. Strikingly, at a conceptual level, the ecological paradigm is isomorphic with PBS in several respects: It deals with units larger than the individual (i.e., systems), it emphasizes natural settings rather than institutions or clinics as being most appropriate for carrying out research and intervention studies (i.e., it emphasizes ecological va-

lidity), and it views research as comprising an ongoing collaboration between scientists and stakeholders. The confluence of these ideas has led to three theoretical principles that have long characterized community psychology and the related fields referred to earlier (Levine & Perkins, 1987), principles that have now become dominant motifs within PBS as well.

The first principle embodies the idea that since people in community settings are interdependent, clinically significant change occurs in social systems and not just in individuals. This notion, a major theme in ecological systems theory (Bronfenbrenner, 1989), manifests itself in PBS with the idea that the focus of intervention must be on changing problem context, not problem behavior. We must move beyond blaming the victim (e.g., certain people have problems that must be "treated") to holding societal contexts accountable (e.g., certain people live in deficient environments that must be redesigned). The second principle embodies the idea that producing change is not simply a matter of implementing specific techniques; rather, change involves the reallocation of resources such as time, money, and political power. Thus, administrative support, interagency collaboration, funding mechanisms, and commonality of mission philosophy are critical variables in the change equation (Dunlap et al., 2000; Knoster et al., 2000; Sailor, 1996). The third principle embodies the idea that an individual's behavior, appropriate or inappropriate, is the result of a continuous process of adaptation reflecting the interface between competence (a property of individuals) and context (a property of environments). Therefore, a successful intervention must modulate the goodness of fit between competence and context (see Albin et al., 1996, for a recent formulation of this idea). This goal is achievable by promoting skill development (a competence variable) in an integrated fashion with environmental redesign (a context variable). Exemplary intervention must involve multicomponent systems change, which, as noted earlier, constitutes the heart of PBS.

Another important aspect of systems change theory relates to the fact that many societies, including our own, are multicultural in nature. Family systems, for example, are characterized by considerable cultural heterogeneity. Effectiveness of community-based research and services therefore depends on knowledge of this heterogeneity. Thus, adherents of PBS have welcomed and are influenced by the theoretical perspectives inherent in cultural psychology, anthropology, and sociology. Cultural variables can have a profound influence on values, communication, interpersonal behavior, and social perception (Matsumoto, 1996). If one is not knowledgeable about these influences and sensitive to them, then the most well-intentioned and best-designed interventions may nonetheless fail. Although no culture is totally homogeneous with respect to goals, every culture deems certain goals to be normative and desirable. In illustration, for many who work with families, a common goal is to make a child autonomous and self-reliant. This choice of goals reflects the premium that Western cultures place on independence. In contrast, many Asian cultures (e.g., the Japanese culture) place a premium on interdependence, that is, on belongingness, dependency, and reciprocity (Weisz, Rothbaum, & Blackburn, 1984); an emphasis on autonomy and self-reliance per se is seen as a sign of selfishness and immaturity. Also, in Western culture, seeking help for social and emotional problems is seen as rational and constructive, whereas in traditional Chinese culture, it is seen as shameful; only when problems are somaticized (e.g., "his strange behavior reflects an underlying 'liver' problem") is it permissible to seek help (Kleinman, 1980). These two examples make clear that cultural insensitivity on the part of intervention agents would likely produce noncompliance or outright avoidance if Asian families were involved. For this reason, attention must be paid to assessing, from a cultural perspective, differences pertaining to family structure and childrearing practices, family perceptions and attitudes, and language and communication styles (Lynch, 1998). In sum, the systemic, community-based, multicultural aspects of PBS lead naturally to a consideration of multiple theoretical perspectives that, in turn, guide the continued evolution of this approach.

A Vision of the Future

The continued evolution of PBS along the lines that we have discussed is likely to lead to substantive changes in at least four areas: (a) assessment practices, (b) intervention strategies, (c) training, and (d) extension to new populations.

ASSESSMENT PRACTICES

The focus on quality-of-life issues, life span perspectives, stakeholder participation, and systems change necessitates a greater reliance on alternative approaches to assessment. The traditional approach to assessment has tended to be microanalytic in nature, emphasizing the analysis of the effects of specific antecedent and consequent stimuli on discrete topographies of behavior. Current developments within PBS suggest that although the microanalytic approach will be retained, a greater emphasis will be placed on an emerging macroanalytic approach that relies on focus groups, expansion of the unit of analysis, evolution of user-friendly measures, and delineation of molar dependent variables.

Since PBS is community based, the relevant stakeholder constituency is diverse and includes not only practitioners but also administrators, policymakers, families, friends, individuals with disabilities, and teachers. There-

fore, focus groups and other sources of multiperspective, narrative-discursive data are needed to assess and identify the full array of stakeholder priorities, the structural and organizational barriers to success, feasibility of proposed solutions, and effective packaging of change strategies (Ruef et al., 1999). This systemic approach to assessment moves the field beyond a sole consideration of discrete behaviors to a consideration of what interested parties have to say about their vision and values, incentives for problem solving, resource allocation, and the infrastructure of available supports (Knoster et al., 2000). Discursive-narrative methodologies are inherent in both the personal futures planning and wraparound approaches discussed earlier (e.g., Kincaid, 1996; Eber, 1997), and it is likely that these approaches to the assessment of personal as well as systemic needs will become preferred and more prevalent in the future.

The systems orientation of PBS is another factor leading to changes in assessment practices. Specifically, the traditional emphasis on the behavior of individuals as the unit of analysis is being broadened to include larger units. This movement reflects greater sensitivity to issues that have long been the concern of professionals in the fields of school and educational psychology. For example, in schools, adherents of PBS have expanded the unit of analysis to capture group behavior at the level of entire classrooms and, even further, at the level of entire buildings (Lewis & Sugai, 1999; Sugai et al., 2000; Warren et al., in press). In taking PBS "to scale," researchers and practitioners are attempting to address the practical realities of carrying out assessment at a systemwide level, often involving hundreds, and sometimes thousands, of children. In this context, it is not possible to study behavior, one child at a time, using traditional assessment strategies. Thus, the development of assessment tools that measure changes in these expanded units of analysis is an important future direction for the field.

Because PBS involves the participation of diverse stakeholders who must function in complex community systems, traditional assessments involving the use of formal functional analysis are generally not workable. We articulated this point earlier, in the discussion of flexibility in scientific practices, and noted the ever-increasing reliance of practitioners on qualitative measures, ratings, interviews, questionnaires, and the like. An important issue for the future of PBS is whether these diverse assessment measures have a degree of validity that permits effective intervention planning. Some recent data (Yarbrough & Carr, 2000) suggested that identifying the parameters within which user-friendly assessments, such as those based on interviews, for example, show convergent validity with more formal assessments, such as those based on functional analysis, is a complicated issue that the field will have to address. We need to develop a set of decision rules and procedures for determining when user-friendly, pragmatic assessment tools are valid and can therefore be employed by practitioners who do not have the time, the control, or perhaps even the training to carry out experimental (functional) analyses. PBS will only reach its full potential when new assessment tools are developed that do not depend on the availability of a small group of highly trained and often unavailable experts.

Finally, the emphasis of PBS on quality-of-life issues and life span perspectives requires that the scope of assessment be expanded to include molar dependent variables (Carr et al., 1998). Traditionally, the main focus has been on causal analyses involving the influence of discrete antecedent and consequent stimuli on well-defined, temporally circumscribed units of behavior. The PBS focus not only includes this type of analysis but also includes assessments related to the influence of broad contextual variables operating over protracted periods of time. Therefore, molar assessments must be developed to capture the effects of systemic changes related to friendship networks (e.g., sociometric analysis), vocational placement (e.g., work productivity, work satisfaction), living environments (e.g., autonomy, self-determination), educational arrangements (e.g., social acceptance, self-esteem, academic competence), and leisure situations (e.g., consumer satisfaction). The use of assessment strategies related to molar dependent variables is essential if we are to fully understand the impact of systems changes on quality of life over time.

In sum, the future is likely to see changes with respect to the who, where, how, and what of assessment: who (e.g., focus groups and key stakeholders, not just experts, will play an increasing role), where (e.g., schoolwide settings, not just individual tutorial situations), how (e.g., user-friendly indirect assessments, not just formal experimental analyses), and what (e.g., sociometric analysis, not just discrete social behaviors).

INTERVENTION STRATEGIES

Because intervention is linked directly to assessment within the PBS framework, there will also be changes in the who, where, what, and when of intervention. With respect to "who," for more than three decades, researchers, psychologists, and other experts have implemented intervention. Yet, the PBS emphasis on ecological validity necessitates a movement toward natural supports in the community, that is, typical intervention agents. Although the recent increase in the involvement of parents and teachers represents a constructive step in this direction, it is not enough. Most people have a broad network of social supports that includes siblings, friends, grandparents, neighbors, and others whose involvement in intervention has rarely been tapped. The participation of this extended

circle of people as active intervention agents in socially supportive roles is likely to become an important feature of PBS.

With respect to "where," the traditional approach has emphasized laboratory, clinic, and segregated institutional settings. Again, however, ecological validity concerns are pressing the field of PBS to carry out interventions in naturalistic, community-based settings. Home, school, and workplace represent a good beginning, but they constitute only a small portion of the universe of possibilities. The future will see the extension of this approach to settings that most of us experience, including restaurants, movie theaters, sports venues, churches and synagogues, social clubs, and vacation places. Expanding the variety and breadth of intervention agents and settings will be a sign that PBS has matured to the highest level of ecological validity.

The focus on comprehensive lifestyle change and quality-of-life issues will drive the field toward a reconceptualization of the "what" of intervention. Thus, in the past, the question has often been, "What intervention (singular) is most appropriate for dealing with a particular problem?" It has become clear, however, that the multidimensional nature of quality of life requires, in turn, a multicomponent (plural) approach to intervention. Further, the components are not necessarily discrete intervention procedures in the traditional sense. For example, extinction (a discrete procedure) may be one component; however, environmental redesign, including architectural variables, social systems, sequences of daily routines, respite care, resource allocation, and development of support networks, may also be involved even though they are not the type of discrete intervention variables that have dominated the field for many years. There will be a greater concentration of effort designed to identify these molar variables and create decision rules regarding how best to combine multiple components into a comprehensive package that addresses the needs of people with disabilities as well as their families and friends.

The PBS focus on prevention will also influence the "when" of intervention. As noted, PBS is an approach in which intervention and support strategies are implemented in a proactive fashion with a view to reducing future occurrences of behavior challenges. Recently, for example, functional communication training has been used with young children to prevent the emergence of serious problem behavior (Reeve & Carr, 2000). There is a clear need to extend this type of demonstration. Specifically, we should be able to identify, early on, the multiple deficiencies in skills and environments that eventually lead to problem behavior and result in a poor quality of life. When these risk factors are better explicated, we will be in a position to teach carefully selected and delineated skills as well as to design living environments proactively before any behavior challenges manifest themselves. In this manner, the direction of the field will be changed from its traditional focus on problems and difficulties to a new positive focus on building on an individual's strengths and creating living environments that support a high quality of life.

TRAINING

Several critical features of the PBS approach ensure that there will be innovations in the who, where, and what of training. There is likely to be continued movement away from an emphasis on simply training experts in university settings who subsequently go out into the field to instruct others. Instead, there will be a movement toward training interprofessional teams, often including parents, that reflects the PBS focus on stakeholder participation. At one level, this trend will involve a collaborative relationship between expert professionals on the one hand and parents, teachers, residential and work support staff, and childcare providers on the other. Collaboration will occur with respect to case formulation, goal setting, intervention selection, and ongoing programmatic change made within a collegial and egalitarian model of operation that would eventually extend to administrative staff and, ultimately, lead to interagency collaboration (Anderson et al., 1996). Thus, training will be viewed not simply as a transfer of strategic information from experts to providers but rather as a process of mutual education involving capacity building that ultimately results in systems change as opposed to narrowly defined changes for a particular individual.

The future should see a de-emphasis on lecture formats carried out within the confines of university settings and formal workshops, and a greater emphasis on on-site education. That is, the PBS emphasis on ecological validity will require that the training of professionals, families, and direct service providers take place in typical settings in neighborhood schools, work sites, community residences, and other locations in the community (e.g., restaurants, shopping malls, theaters). Meaningful training involves in vivo problem solving within real-life contexts occurring for time durations sufficient to produce trainee competence (Anderson et al., 1996). It is likely that these situational training innovations will be greatly enhanced by creative use of new information technologies, including CD-ROM and online, Web-based instructional methods (Sailor et al., in press).

Because of the critical PBS feature of systems change, it will no longer be sufficient to train people to master a laundry list of specific intervention techniques (e.g., extinction, prompting, reinforcement); rather, people will also need to know how to deal with the systems in which intervention strategies are embedded and how to integrate technology within broader support infrastructures and networks. Thus, the content of training will also have to include knowledge of administrative issues, funding mech-

anisms, mission and philosophies, and interagency collaboration (Dunlap et al., 2000).

EXTENSION TO NEW POPULATIONS

PBS has made many valuable contributions to improving the quality of life of people with developmental disabilities. It is not surprising, therefore, that there is a mistaken perception that the approach is applicable primarily to this population. In fact, there is growing evidence that PBS is undergoing a rapid extension to other populations as well. Already, the application of PBS has expanded to include people with traumatic brain injury (Singer, Glang, & Williams, 1996; Ylvisaker & Feeney, 1998), typically developing children with school discipline problems (Burke & Burke, 1999; Lewis & Sugai, 1999; Sugai et al., 2000; Warren et al., in press), and children and youth with emotional and behavioral disorders (Dunlap & Childs, 1996; Dunlap, Clarke, & Steiner, 1999; Kern, Childs, Dunlap, Clarke, & Falk, 1994). The extension of PBS represents part of a larger movement in the social sciences and education away from traditional models that have emphasized pathology and toward a new positive model that emphasizes "a science of positive subjective experience, positive individual traits, and positive institutions" (Seligman & Csikszentmihalyi, 2000b, p. 5) with a view to improving quality of life and preventing behavior problems (Seligman & Csikszentmihalyi, 2000a).

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to understand), and that embraces information from various research traditions as credible sources. I believe that this is what Carr and colleagues are trying to say. Inviting others into the conversation can help to make this more inclusive view of science more explicit.

Summary

So, are you a behaviorist or a bonder, or an organizational theorist, an ecological psychologist, a community psychologist, a systems analyst, or a cultural anthropologist? Are you a single-subject, large *N*, or interpretivist researcher? Do you ascribe to positivist, postpositivist, natural inquiry, or postmodernist assumptions? I don't know. What I do know is that I am committed to figuring out how to provide respectful and dignified supports for people with disabilities who engage in challenging behaviors, supports that will ultimately result in meaningful outcomes for these people and their families. In the final analysis, this is what positive behavior support is all about.

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REDUCTION OF SEVERE BEHAVIOR PROBLEMS IN THE COMMUNITY USING A MULTICOMPONENT TREATMENT APPROACH

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Problem behavior often prevents community integration of people with developmental disabilities. Therefore, we evaluated a multicomponent approach for remediating problem behavior in public community settings (specifically, supermarkets). We selected treatments based on hypotheses about the variables controlling the problem behavior (hypothesis-driven model). The multicomponent intervention included choice making, embedding, functional communication training, building tolerance for delay of reinforcement, and presenting discriminative stimuli for nonproblem behavior. Treatment progress was monitored using measures of latency and task completion rather than traditional measures of frequency and time sampling. Results showed substantial increases in task completion and duration of time spent in supermarkets without problem behavior. Outcomes were socially validated by group-home staff and cashiers. We discuss how the intervention approach taken can resolve some of the issues involved in assessing, measuring, and treating problem behavior in the community.

DESCRIPTORS: community-based treatment, functional analysis, aggression, problem behavior, developmental disabilities

A dominant theme in the literature on developmental disabilities has been the importance of fully integrating people with a variety of handicaps into the community (Kennedy & Haring, 1992; Meyer, Peck, & Brown, 1991; Scotti, Evans, Meyer, & Walker, 1991). Community integration has included a focus on the school (Sailor et al., 1989), the workplace (Rusch, 1990), and recreation and leisure (Wehman & Schleien, 1981). Unfortunately, several decades of research suggest that the presence of severe problem behavior may seriously jeopardize the successful participation of people with developmental disabilities in the community (Eyman, Borthwick, & Miller, 1981; Nihira & Nihira, 1975; Windle, Stewart, & Brown, 1961), often leading to their isolation or even institutionalization. This fact argues for remediation of problem behavior as one facet of an overall strategy to facilitate integration.

A common community activity for people without disabilities involves shopping in a public place such as a supermarket (Clark et al., 1977). Consistent with the emphasis on integration, the literature has delineated the procedures needed to establish shopping skills in people with disabilities (Aeschleman & Schladenhauffen, 1984; Gaule, Nietupski, & Certo, 1985; Matson, 1981; McDonnell, 1987; Nietupski, Welch, & Wacker, 1983; Wheeler, Ford, Nietupski, Loomis, & Brown, 1980). Although all studies reported successful outcomes and enhanced community participation, none of the studies involved individuals who exhibited severe problem behavior. One purpose of our study, therefore, was to identify procedures that would enable individuals who exhibit severe problem behavior to shop successfully in a supermarket without endangering themselves or others.

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Because problem behavior that occurs in complex community settings is often controlled by multiple factors, successful remediation will almost certainly involve the use of multiple treatments (Carr, Robinson, Taylor, & Carlson, 1990; Haring & Kennedy, 1990; Horner et al., 1990; Iwata, Vollmer, & Zarcone, 1990; Wacker & Steege, in press). Therefore, a second purpose of our study was to describe and evaluate a logically derived multicomponent intervention.

Traditionally, interventions have been evaluated using measures of frequency and time sampling. These measures are especially appropriate in home and school settings where parents or professional staff monitor the problems. In these settings, there is an understanding that problem behavior is likely to occur in baseline and must be tolerated, at least in the short run, for purposes of assessment. No such tolerance exists in a public supermarket. Instead, even a relatively small number of instances of property destruction or aggression against other patrons results in expulsion from the store or police action. Also, caretakers who accompany individuals with disabilities to the store are embarrassed by public displays of problem behavior and are, therefore, not likely to agree to monitor progress using frequency or time-sampling measures. In light of these practical difficulties, it is desirable to have alternative measures for use in public settings. Accordingly, a third purpose of our study was to evaluate the utility of measures of latency to problem behavior and percentage of task completion as alternatives to measures of frequency and time sampling. The rationale for employing these measures was that, in the community, we are less concerned with rate or level of problem behavior and more concerned with whether an individual can complete a shopping task in a reasonable amount of time and can do so without engaging in problem behavior.

METHOD

Subjects and Setting

Subject selection was made on the basis of interviews with group-home staff members who worked in a program serving people with developmental disabilities. The first 3 people who met all of the following criteria were selected for inclusion in the study: (a) a history of serious behavior problems displayed in community settings; (b) the problem behavior included any combination of aggression, property destruction, self-injurious behavior, and tantrums; and (c) the individual was currently excluded from participating in community activities because of past displays of problem behavior in the community. To initiate the hypothesis generation process, we also asked staff members why they thought particular individuals misbehaved. For each individual, staff members consistently hypothesized that problem behavior was a function of either escape from aversive stimuli or tangible reinforcement, depending on the situation.

The medical staff had diagnosed all 3 individuals as autistic. Mark was 18 years old; on the Stanford-Binet (L-M), he received a mental age score of 5 years, and his language age was determined to be 3.85 years on the Mecham Verbal Language Development Scale. Mark communicated in three- to seven-word sentences and initiated requests to make his basic needs known. Bob was 17 years old; his mental age was 3 years 10 months (Stanford-Binet) and his language age was 3.5 years (Communication Evaluation Chart). He communicated using single-word labels. Danny was 16 years old; his mental age was 2 years (Stanford-Binet) and his language age was 3.38 years (Mecham scale). He was echolalic but could use two- to five-word sentences to express basic needs. All 3 individuals could follow simple one-step verbal directions. A variety of interventions, including time-out, response cost, and token economies, had been used unsuccessfully in the past to manage problem behavior.

All sessions were carried out in four supermarkets normally used by the group-home staff in their shopping expeditions.

Procedure

Baseline and assessment. Three to five sessions were conducted per week, half of the sessions in the morning and half in the afternoon. Sessions were distributed equally and randomly across the

Table 1
Shopping Task Sequence

Step	Discriminative stimulus (cue)	Correct response
1. Enter store	Nonverbal: Exiting from parked car in supermarket lot Verbal: "Let's go shopping"	Walks toward entrance within 5 s and subsequently enters store
2. Get a shopping basket or cart	Nonverbal: Stack of baskets or row of carts in sight Verbal: "Get a basket, please"	Gets a basket or cart within 5 s
3. Get Item 1 (on shopping list)	Nonverbal: Standing in front of item Verbal: "Get _____ , please"	Initiates search for item within 5 s and subsequently obtains item, placing it in basket or cart
4. Get Item 2	Same as above	Same as above
5. Get Item 3	Same as above	Same as above
6. Go to the checkout line	Nonverbal: All items present in basket or cart Verbal: "Go to the cashier, please"	Walks to checkout line within 5 s
7. Wait in line	Nonverbal: Standing behind last person in line Verbal: "We have to wait here"	Remains in line
8. Place items on counter	Nonverbal: Standing adjacent to counter Verbal: "Put the groceries on the counter, please"	Puts groceries on counter within 5 s
9. Hand money to cashier	Verbal: Cashier states total price Verbal: "Give the money to the cashier, please"	Gives money within 5 s
10. Wait for change	Nonverbal: Cashier holds out change Verbal: "Get the change, please"	Takes change within 5 s
11. Pick up bag of items	Nonverbal: Cashier places bag of items on counter Verbal: "Get the bag, please"	Picks up bag within 5 s
12. Exit and go to vehicle	Nonverbal: Has grocery bag in hand Verbal: "Let's go to the car"	Walks to exit within 5 s and proceeds to car in parking lot

four supermarkets. Three staff members from each of the three group homes were assigned to carry out sessions under the direct supervision of the second author. Staff members had 6 to 18 months of experience working in the group homes. Each session consisted of the 12-step shopping sequence shown in Table 1. This sequence was based on the task analysis outlined by Brown et al. (1978). The items purchased varied from session to session depending on the supply needs of the group homes. Staff members were asked to construct a list of items known to be preferred or not preferred by individual residents. The proportion of preferred and nonpreferred items was held constant over the course of the study. Staff members employed the general procedures that they typically used on shopping trips. Specifically, the discriminative stimulus for responding on each step consisted of a nonverbal cue plus a verbal cue presented by the staff person (with the exception of Step 9, as noted). Consider Step 1 ("Enter store"). The nonverbal cue consisted of a specific natural stimulus, namely, exiting from the parked car in the supermarket lot. The accompanying verbal cue for this step was the sentence, "Let's go shopping." If the resident responded correctly to these cues within 5 s, the staff person provided positive feedback that was appropriate to the context (e.g., for Step 1, "O.K., Mark, we're on our way now"). If the resident did not respond or made an incorrect response (e.g., walked in the opposite direction from the store entrance), a sequence of consequences was used. First, the staff member provided corrective feedback and presented the verbal cue again (e.g., "No, you're going the wrong way. Let's go shopping"). If the resident failed to respond correctly, the staff member pro-

vided the verbal cue plus a gestural prompt (e.g., pointing to the store entrance). If the gestural prompt failed, the staff member presented the verbal cue plus a physical prompt (e.g., placing a hand on the back of the resident and gently guiding him towards the store entrance).

The session continued until all steps of the shopping sequence were completed or until the resident displayed either of two criterion levels of problem behavior. If either of the criterion levels were met, the session was terminated and the resident was escorted out of the store. Different criteria were used depending on whether the problem behavior was designated as untolerated or tolerated. Pilot observations had suggested that certain problem behaviors were less well tolerated than others by significant members of the community (i.e., cashiers, store managers, security police, and other customers). A single instance of such behavior evoked complaints from other people and, often, expulsion from the store. Therefore, a single instance of untolerated behavior was the criterion used for session termination. Untolerated problem behavior included (a) aggression or attempted aggression towards another person (hitting, punching, kicking, biting, grabbing, or shoving others; striking another person with an object; or attempting any of these behaviors but missing the victim because he or she successfully avoided the attack), (b) aggression against property (striking, throwing, or destroying an object or physical structure), and (c) more than 5 s of screaming accompanied by throwing oneself on the floor and flailing the arms and legs. Pilot observations had also suggested that certain problem behaviors were tolerated provided that they did not occur too often. Therefore, a different criterion was used for session termination in the case of tolerated problem behavior. Specifically, the session was terminated when any three instances of the following tolerated behaviors occurred within a session: (a) 5 s or less of screaming unaccompanied by other problem behavior, (b) self-injury (hitting self in face once with open hand), and (c) 2 to 5 s of stomping feet on the floor accompanied by loud vocalizations.

During baseline, an additional descriptive observational assessment was undertaken as an aid to subsequent treatment planning. The purpose of this assessment was to collect information that could later be used to generate plausible hypotheses concerning the variables that maintained problem behavior. The second author and a research assistant compiled an anecdotal record of each episode of problem behavior that occurred (Table 2). Situations that evoked problem behavior less than three times across all baseline sessions were not considered in hypothesis generation. Each of the 18 problem situations listed in Table 2 for the 3 residents occurred many more than three times each in baseline and accounted for virtually all instances of observed problem episodes.

Treatment. Sessions were conducted once or twice each day at various times of the day in the same four supermarkets used in baseline. As in baseline, a session continued until the 12-step shopping sequence was completed or until the resident displayed either of the two criterion levels of problem behavior. The second author trained all participating staff members in the use of the treatment procedures.

Prior to implementing treatment procedures in the supermarket, staff members received five 20-min sessions of training in which the rationale for each procedure was explained and the procedure itself was modeled. Staff members were then required to demonstrate use of the procedure on one another, after which they received corrective or supportive feedback as appropriate. During the first supermarket session, the second author prompted each staff person on what to do as each problem situation in Table 2 arose. In subsequent sessions, the second author provided prompts only if the staff person failed to implement the required treatment within 5 s of the onset of the problem situation. Prompts were gradually faded for staff members after three, five, and eight treatment sessions for Mark, Bob, and Danny, respectively.

Each resident participated in a multicomponent treatment intervention consisting of five procedures: choice, embedding, functional communication training, building tolerance for delay of reinforcement, and presentation of discriminative stimuli for nonproblem behaviors.

Table 2
Problem Situations, Hypotheses Regarding Variables Maintaining Problem Behavior, and Treatments Based on These Hypotheses

Mark	1. Problem situation: After entering store, he turns around and runs toward exit. If he is escorted out the door, he is calm. If he is prevented from leaving, he screams, stomps feet, hits or punches staff person who prevents him from leaving. Hypothesis: Escape from store because store is associated with a variety of aversive shopping tasks. Treatment: Choice of initial activity.
	2. Problem situation: He is asked to get a nonpreferred item from shopping list (e.g., soap). Responds by shoving staff person and running away. Hypothesis: Escape from demand to get nonpreferred item. Treatment: Choice of alternative preferred activities. Embed demands.
	3. Problem situation: He asks for prohibited item (e.g., salty foods such as pretzels not allowed because of his high blood pressure) and is told he cannot have it. Responds by grabbing item and tearing it open. Aggresses against staff members who try to prevent access to item. Hypothesis: Tangible reinforcement in the form of prohibited item. Treatment: Choice of alternative reinforcers (e.g., pretzels low in salt content).
	4. Problem situation: He is standing in front of preferred item. Grabs item. Aggresses against staff members who try to prevent access to item. Hypothesis: Tangible reinforcement in the form of preferred item. Treatment: Functional communication. Tolerance for delayed reinforcement.
	5. Problem situation: He is asked to terminate an activity involving a preferred item (e.g., reading labels on boxes of pasta). He responds by screaming and aggressing against staff person while holding on to preferred item. Hypothesis: Tangible reinforcement in the form of preferred item. Treatment: Choice of alternative reinforcers (e.g., a different preferred item).
	6. Problem situation: While waiting in line behind other customers at checkout, he becomes aggressive to the customers and/or staff. Hypothesis: Escape from demand to wait in line. Treatment: Present discriminative stimuli for nonproblem behavior.
Bob	1. Problem situation: Same as 1 for Mark. If he is prevented from leaving, he screams, hits himself on head. Hypothesis and treatment: Same as 1 for Mark.
	2. Problem situation: Same as 2 for Mark. Responds by slamming cart on floor and aggressing against staff person. Hypothesis and treatment: Same as 2 for Mark.
	3. Problem situation, hypothesis, and treatment: Same as 4 for Mark.
	4. Problem situation: He is given a gestural prompt because he did not respond to a request to get a nonpreferred item. He screams, hits himself on head. Hypothesis: Escape from gestural prompt. Treatment: Choice of alternative preferred activities. Embed demands.
	5. Problem situation: He is given a physical prompt because he did not respond to a gestural prompt. He smashes item with fist. Hypothesis: Escape from physical prompt. Treatment: Choice of alternative preferred activities. Embed demands.
	6. Problem situation, hypothesis, and treatment: Same as 6 for Mark.
Danny	1. Problem situation: After entering store, he runs to checkout line and grabs items from other customers. If staff intercede to block the grabbing, he becomes aggressive. Hypothesis and treatment: Same as 4 for Mark.
	2. Problem situation, hypothesis, and treatment: Same as 2 for Mark.
	3. Problem situation: He is walking down an aisle and another customer passes him with a cart of groceries. He grabs the other customer's items. If staff members intercede to block the grabbing, he becomes aggressive. Hypothesis and treatment: Same as 4 for Mark.
	4. Problem situation: Same as 4 for Bob. He screams, hits himself on head, and aggresses against staff person. Hypothesis and treatment: Same as 4 for Bob.
	5. Problem situation, hypothesis, and treatment: Same as 6 for Mark.
	6. Problem situation: While waiting for the cashier to ring up the items, he grabs pens from cashier. If staff members intercede to block the grabbing, he becomes aggressive. Hypothesis: Tangible reinforcement (the pens). Treatment: Functional communication.

The particulars of each problem situation (Table 2) were examined and used to formulate hypotheses concerning the variables thought to maintain problem behavior in each case. The hypotheses, in turn, were used to select specific treatment procedures. Our treatment approach therefore conformed to the hypothesis-driven model articulated by Repp, Felce,

and Barton (1988) and Repp and Karsh (1990). Hypotheses concerning the maintaining variables for problem behavior fell into two categories: escape from putative aversive stimuli, such as task demands and prompts, and tangible reinforcement involving specific grocery store items. These categories corroborated the hypotheses offered by the staff during the interview process described earlier.

Implementation of choice procedures provides the first example of how hypothesis generation was linked to treatment. Consider the first problem situation for Mark listed in Table 2 (aggression when prevented from leaving the store). The store was closely associated with a variety of shopping tasks that regularly evoked noncompliance and other behavior difficulties. Therefore, it was hypothesized that Mark's problem behavior was maintained by escape from the conditioned aversive properties of store stimuli that had become discriminative for forthcoming demands. A procedure was needed to induce him to remain in the store, become engaged in store-related activities, and to do so without exhibiting problem behavior. Allowing individuals to choose activities and reinforcers can produce appropriate engagement with the social and work environment while minimizing disruptive avoidance behaviors (Dunlap, Dunlap, Clarke, & Robbins, 1991; Dyer, Dunlap, & Winterling, 1990; Koegel, Dyer, & Bell, 1987; Parsons, Reid, Reynolds, & Bumgarner, 1990). Therefore, Mark was given choices. Specifically, prior to entering the store, he was asked what he would like to do first after he entered the store. If he failed to choose an activity within 5 s, he was offered a number of options that had been identified from past shopping expeditions. For example, if he had been observed to spend some time examining pens and pencils, magazines, and reading labels off various boxes, he would be asked, "Mark, when we go into the store, would you like to look at the pens and pencils, magazines, or read labels?" After he indicated his choice, staff would accompany him directly to the relevant area of the store and allow him to engage in his chosen activity for 2 to 3 min. The same procedure was in effect for Bob's first problem situation (Table 2).

In several problem situations, choice was combined with a second procedure, embedding. For example, because Mark purchased a preferred item from his shopping list (e.g., potato chips) without incident and was aggressive when asked to purchase a nonpreferred item (e.g., soap), we hypothesized that aggression in Mark's second problem situation was maintained by escape from the demands of purchasing nonpreferred items. A procedure was needed to preempt any emergent problem behavior as well as to induce compliance with the shopping task. A group of procedures variously referred to as interspersal training (Horner, Day, Sprague, O'Brien, & Heathfield, 1991), high-probability request sequences (Mace et al., 1988), pretask requesting (Singer, Singer, & Horner, 1987), task variation (Dunlap, 1984; Dunlap & Koegel, 1980; Winterling, Dunlap, & O'Neill, 1987), and embedding (Carr, Newsom, & Binkoff, 1976) can enhance compliance while minimizing disruptive behavior. The essence of these procedures is to present the problematic task within the context of stimuli known to be discriminative for nonproblem behavior. In the present case, asking Mark to purchase a nonpreferred item (e.g., soap) constituted the problematic task, and providing Mark with an opportunity to engage in (choose) preferred activities constituted the discriminative stimulus for nonproblem behavior. Therefore, Mark was allowed to choose among several preferred activities identified from past shopping expeditions. Once he made a choice, he was allowed to pursue the activity for 1 to 2 min. The procedure was repeated once. Mark was then asked to get the nonpreferred item. That is, the task that had evoked problem behavior was presented within the context of a series of preferred activities chosen by Mark. The combination of choice and embedding was also used in the second, fourth, and fifth problem situations for Bob as well as the second and fourth problem situations for Danny. In several of these situations, gestural and physical prompts (rather than simple requests to purchase a nonpreferred item) were the discriminative stimuli for problem behavior.

For all residents, the procedures just described were in effect during the first session of treatment.

Thereafter, in the interest of efficiency, an attempt was made to decrease the number of times that the choice and embedding procedures were employed. Beginning with the second treatment session, choice and embedding were reintroduced only if a resident displayed an instance of tolerated problem behavior in response to a demand to purchase a nonpreferred item. If the resident responded to the demand without displaying problem behavior, the choice and embedding procedures were not used, and the shopping expedition proceeded to the next step of the task sequence.

Choice was also used in situations in which it appeared that problem behavior was maintained by acquisition of tangible items (as opposed to escape from demands or prompts). For example, when Mark was blocked from obtaining a prohibited snack item, he responded aggressively (third problem situation, Table 2). In such situations, one strategy is to permit the individual to choose substitute items that approximate the target of the request (Durand, 1991). Thus, Mark was given an opportunity to choose among several brands of low-salt pretzels, potato chips, or corn chips. The same strategy was employed to deal with situations in which problem behavior was evoked when Mark was asked to terminate an activity involving a preferred item. In this case, Mark was allowed to choose an alternative preferred activity and engage in it for 1 to 2 min, after which the shopping expedition continued.

Functional communication training constituted a third procedure and was used in the fourth problem situation for Mark (Table 2). It was hypothesized that problem behavior in this situation was maintained by the tangible reinforcement that was received as a consequence of aggression. Research has demonstrated that teaching communicative behaviors that are functionally equivalent to the problem behavior (e.g., obtaining the item by saying, "I want the cookies," rather than by aggressing) can result in reductions in problem behavior (Bird, Dores, Moniz, & Robinson, 1989; Carr & Durand, 1985; Day, Rea, Schussler, Larsen, & Johnson, 1988; Horner & Budd, 1985). Accordingly, in the first treatment session, each time Mark approached an area of the store in which one of the target items (crackers, cookies, potato chips, or soup) was located, a staff person prompted a request (e.g., "Mark, if you want the crackers, say 'I'd like some crackers, please' "). When Mark repeated the prompted statement, he was allowed to have a portion of the reinforcer (e.g., one or two cookies) and the open package was placed in the shopping cart for subsequent purchase. In the case of the soup, the unopened package was placed in the cart for consumption upon arrival at home. In the second treatment session, when Mark approached within 1 m of a preferred item, the staff person waited 3 s for him to make a request, after which a request was prompted. After the second treatment session, if Mark did not make a request as he approached one of the items, he was allowed to walk by the item and continue shopping. A request was followed by presentation of the item. This procedure was also used with Bob in his third problem situation (Table 2), except that time delay was not introduced until the third treatment session, and prompts were not discontinued until the fifth treatment session.

For Danny (first and third problem situations), a slight variant of this procedure was used. Specifically, when he grabbed an item (invariably, either a can of soda or a box of cookies) from another customer, he was prompted to return it to the person and then to make a request to the staff member (e.g., "Danny, you can't take things from other people. Ask when you want something. Say, 'I want some soda' "). He was then taken to the area of the store where, for example, the soda was kept. The remainder of the procedure was the same as that used for Mark, except that delay was not introduced until the third treatment session, and prompts were not dropped until the sixth treatment session. Another variant of the procedure was used in the sixth problem situation for Danny. When he grabbed a pen from the cashier's area, he was prompted to return it to the cashier immediately. Then, he was told, "Danny, you can't grab things without asking. Say, 'May I borrow your pen?' " Following the request, the cashier provided the pen and the staff person told Danny to cross off all the

items on his shopping list, a strategy designed to engage him in a socially appropriate behavior.

Building tolerance for delay of reinforcement was the fourth procedure in the multicomponent treatment approach. This procedure was added to functional communication training once the resident was independently requesting preferred items. Pilot observations showed that, in Mark's fourth problem situation, he requested one preferred item after another, thereby never accomplishing any grocery shopping. To remedy this problem, we implemented a procedure in which a request (e.g., "I want the cookies") was followed by a shopping demand (e.g., "Sure, Mark, you can have the box of cookies but first, let's get one of the things on our shopping list and then we'll come back"). Mark was then accompanied to the area of the store where the item on the shopping list was located. Once he had placed that item in the basket, he was permitted to return to the cookie area and obtain the item requested. The time that it took Mark to get the item on the shopping list constituted a delay between his initial request (e.g., for the cookies) and delivery of the requested item. In the first session that delay of reinforcement was put into effect, the delay was programmed by asking Mark to get only one item from his shopping list. By the next session, the delay involved having Mark get two items and, for all subsequent sessions, three items. In this manner, delay of reinforcement gradually increased over time, as was (implicitly) the response requirement for reinforcement. This procedure was also in effect in Bob's third problem situation and in Danny's first and third problem situations.

Presenting stimuli discriminative for nonproblem behavior was the fifth procedure used in the multicomponent treatment approach. Consider the sixth problem situation for Mark. When asked to wait in line behind other customers at the checkout stand, he would often become agitated after 1 to 2 min. If he were then prevented from leaving, he would strike out at the staff person or nearby customers. It was hypothesized that problem behavior in this situation was maintained by a history of negative reinforcement for aggression through escape from having to wait in line. A procedure was needed that would result in waiting without accompanying aggression. It is sometimes possible to introduce stimuli that are discriminative for nonproblem behavior in otherwise problematic situations; by doing so, one can prevent the emergence of problem behavior (Touchette, MacDonald, & Langer, 1985). By restructuring their clinical situation so that new environmental conditions predominated, Touchette et al. were able to prevent problem behavior from recurring. In parallel fashion, we noted that Mark never exhibited problem behavior while reading magazines (one of his favorite activities). Therefore, as we approached the checkout stand, we prompted Mark to take a magazine from the nearby rack and read it. Prompts were discontinued after two sessions. The magazine was discriminative for nonproblem behavior (reading). This procedure was applied with a different discriminative stimulus for nonproblem behavior in Bob's sixth problem situation and Danny's fifth problem situation. Specifically, they were allowed to consume a preferred item that they had purchased (e.g., potato chips or cookies). Bob and Danny had never displayed problem behavior while eating potato chips or cookies; thus, these activities were clearly discriminative for nonproblem behavior.

Treatment was terminated after each resident had completed 90% or more of the steps in the shopping sequence without displaying criterion levels of problem behavior for four consecutive sessions. At this point, the maintenance phase of the study began.

Maintenance. Maintenance sessions were conducted using the same procedures described for baseline. However, staff members implemented the treatment procedures independently with no further training, prompts, or feedback from the authors. To demonstrate the durability of treatment effects, the residents participated in a large number of maintenance sessions (35, 30, and 25 sessions for Mark, Bob, and Danny, respectively). Once maintenance effects were demonstrated, the number of

Table 3
Social Validity Data for Group-Home Staff

	Mark		Bob		Danny	
Rater	Pre	Post	Pre	Post	Pre	Post
1. I am afraid to take this resident shopping.						
1	5	1	6	1	4	1
2	3	1	2	1	4	1
3	7	1	5	1	4	1
M	5.0	1.0	4.3	1.0	4.0	1.0
2. I feel confident that I can control him in the store.						
1	2	6	7	7	3	6
2	3	7	3	7	4	6
3	3	7	5	6	3	7
M	2.6	6.6	5.0	6.6	3.3	6.3
3. This resident's problem behavior in the store is very severe.						
1	4	1	5	1	5	2
2	5	1	4	1	2	1
3	5	3	4	2	4	1
M	4.6	1.6	4.3	1.3	3.6	1.3

Note. Each question was rated on a 7-point scale, with 7 representing "very much/always," 4 representing "somewhat/sometimes," and 1 representing "not at all/never."

Table 4
Social Validity Data for Supermarket Cashiers

Cashier	Mark	Bob	Danny
1. I am frightened by this person's behavior.			
1	1	1	1
2	1	1	1
3	4	1	1
M	2	1	1
2. It is all right for this person to shop in the supermarket.			
1	7	7	7
2	7	4	7
3	4	7	7
M	6	6	7

Note. Each question was rated on a 7-point scale (see Table 3).

items on the shopping list was increased from three to five for three sessions, then from five to seven for three more sessions, and, finally, from 7 to 10 for a varying number of sessions for each resident.

Social validity. The three staff members from each resident's group home were asked to fill out a three-item 7-point Likert-type questionnaire (Table 3) at the end of the baseline and maintenance phases. In addition, for each resident, the three cashiers who were present during the greatest number of sessions were selected to fill out a two-item 7-point Likert-type questionnaire (Table 4). Because the residents had almost no contact with the cashiers during baseline (i.e., residents' problem behavior invariably resulted in their having to be escorted out of the store prior to completion of the shopping expedition), ratings were made at the end of the maintenance phase only. Therefore, the ratings of the cashiers (in contrast to those of the staff members) were valuable only as a measure of post-treatment impact and social acceptability rather than as a measure of behavior change per se. Nonetheless, validation of treatment outcome by members of the community is an important ancillary index of intervention efficacy.

Response Recording and Interobserver Agreement

Two dependent variables were recorded: percentage of task steps completed and latency. Percentage of task steps completed was defined as the number of task steps performed correctly before session termination (due to problem behavior or successful completion of the shopping expedition) divided by the total number of steps in the shopping sequence, multiplied by 100%. The total number of steps in the shopping sequence varied from 12 (reflecting the three-item shopping list used in the initial phase of maintenance) to 19 (reflecting the 10-item shopping list used at the end of the maintenance phase). The definition of correct performance on each task step is given in Table 1. Latency was defined as the number of minutes that elapsed between the resident's exiting from the car in the parking lot at the beginning of the shopping sequence to (a) the first instance of untolerated problem behavior, (b) the final (third) instance of tolerated problem behavior, or (c) the successful completion of the shopping task sequence. In addition, the number of tolerated problem behaviors in sessions that were not terminated (i.e., less than three tolerated problem behaviors per session) was tallied to provide an index of the frequency of these

behaviors during successfully completed shopping expeditions. Finally, the percentage of steps prompted by staff was an ancillary measure that was recorded to provide an index of task mastery.

The second author served as the primary observer, and an undergraduate with extensive employment experience in the field of developmental disabilities served as the reliability observer. The two observers positioned themselves 0.91 m to 9.10 m from the resident as the resident moved through the store. Each observer held a stopwatch in the palm of his or her hand and recorded on a small index card that listed the task steps as well as a code that indicated whether or not the task was prompted.

Interobserver agreement was assessed throughout the study on 48%, 49%, and 41% of the sessions for Mark, Bob, and Danny, respectively. A binary reliability index was used for latency, percentage of steps completed, frequency of tolerated problem behavior in successfully completed sessions, and percentage of steps prompted; that is, for each session, reliability was scored as either perfect or no agreement. Agreements for the respective measures were defined as a difference of 5 s or less for latency, the same number of tolerated behaviors (either zero, one, or two), and the same number of steps. For percentage of steps prompted, if the two observers listed a prompt on each of the same steps, perfect agreement was scored. The percentage of sessions with perfect agreement was between 92% and 100% for each measure for each of the 3 residents.

Experimental Design

The multicomponent treatment intervention was introduced in a multiple baseline design across subjects.

RESULTS

Figure 1 shows the percentage of steps completed and the latency to problem behavior requiring session termination or the latency to successful completion of the shopping expedition for the 3 residents during the baseline, treatment, and maintenance phases of the study. All residents displayed an increase in the percentage of steps completed from baseline through treatment to initial maintenance (those sessions in which the shopping list consisted of three items) and again in extended maintenance (those sessions in which the shopping list was gradually extended to 5, 7, and then 10 items). Mark reached the criterion for ending the treatment phase (90% or more steps completed for four consecutive sessions) in five sessions; Bob required nine sessions, and Danny required 11. The total training time required to reach criterion was 58 min for Mark, 80 min for Bob, and 96 min for Danny. The mean percentage of steps completed by Mark increased from a baseline level of 30.4% (range, 8.3% to 50%), to an initial maintenance level of 100%, and then to an extended maintenance level of 96% (range, 53% to 100%). The mean percentage of steps completed by Bob increased from 47.3% (range, 8.3% to 100%) in baseline, to 99.7% (range, 91.7% to 100%) in initial maintenance, to 100% in extended maintenance. The mean percentage of steps completed by Danny increased from 20.9% (range, 8.3% to 100%) in baseline, to 89% (range, 33.3% to 100%) in initial maintenance, to 100% in extended maintenance.

The mean latency to behavior problems and the mean latency to completion of shopping without the need to terminate due to problem behavior increased following treatment. The overall mean latency for Mark was 3 min 32 s (range, 7 s to 7 min 6 s) in baseline, 11 min 40 s (range, 9 min 5 s to 13 min 51 s) in treatment, 11 min 23 s (range, 6 min 5 s to 16 min 35 s) in initial maintenance, and 16 min 50 s (range, 10 min 31 s to 31 min) in extended maintenance. The mean latency for Bob was 4 min 5 s (range, 2 s to 9 min 47 s) in baseline, 9 min 11 s (range, 4 min 5 s to 15 min 10 s) in treatment, 9 min 10 s (range, 5 min 27 s to 14 min 42 s) in initial maintenance, and 14 min 25 s (range, 8 min 17 s to 20 min 25 s) in extended maintenance. The mean latency for Danny was 1 min 37 s (range, 8 s to 9 min 6 s) in baseline, 9 min 44 s (range, 2 min 37 s to 12 min 22 s) in treatment, 10 min 26 s (range, 4

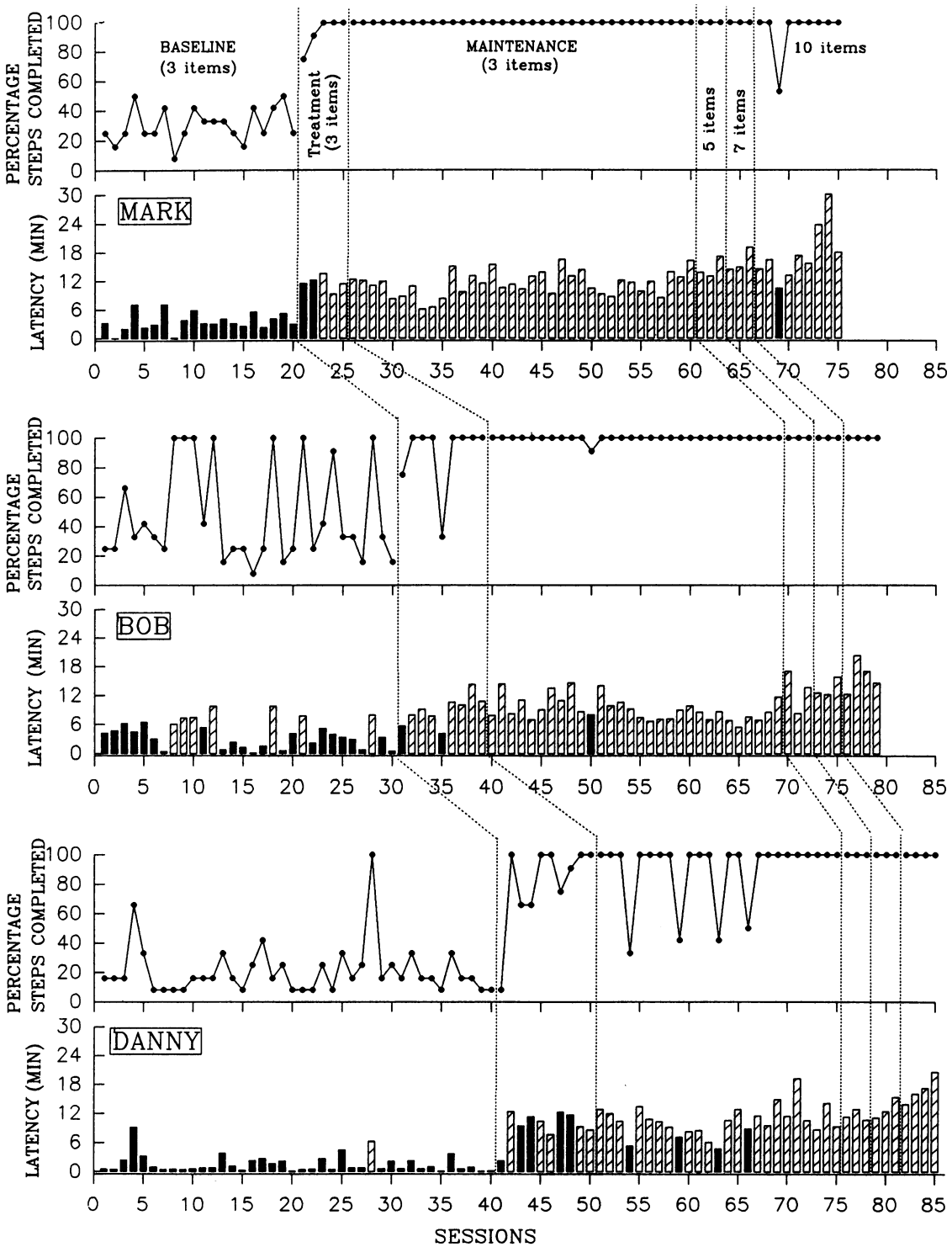

Figure 1. Percentage of steps completed and latency to problem behavior or successful completion of shopping for the 3 residents during the baseline, treatment, and maintenance phases of the study. The solid histograms denote those sessions terminated due to problem behavior, and the diagonal histograms denote those sessions in which shopping was successfully completed without the need to terminate due to problem behavior. The item labels (3, 5, 7, and 10) denote the gradual increase in the length of the shopping list from treatment and initial maintenance to the end of extended maintenance. The abscissa for latency is slightly recessed in order to make short sessions more visible.

min 49 s to 19 min 14 s) in initial maintenance, and 14 min 8 s (range, 10 min 40 s to 20 min 36 s) in extended maintenance. It is clear from the number of solid histograms in Figure 1 that unacceptable levels of problem behavior resulted in few completed baseline sessions. In contrast, in initial and extended maintenance, sessions were almost always completed without the need for session termination due to problem behavior.

The data also show that tolerated problem behavior in sessions that were not terminated was extremely rare following treatment. Mark displayed a mean of 0.09 tolerated problem behaviors per session in initial maintenance and none in extended maintenance. Similarly, Bob displayed a mean of 0.3 in initial maintenance and 0.2 in extended maintenance. Danny displayed a mean of 0.08 in initial maintenance and 0.02 in extended maintenance. The percentage of successfully completed sessions in which there were no tolerated problem behaviors was 94.3%, 79.3%, and 90.5% for Mark, Bob, and Danny, respectively, during initial maintenance, and 100%, 90%, and 90% for Mark, Bob, and Danny, respectively, during extended maintenance.

The level of prompting during the last four sessions of baseline, treatment, initial maintenance, and extended maintenance was compared. For each resident, there was a consistent pattern of increasing independence from prompts as the study progressed. The level of prompts needed during baseline, treatment, initial maintenance, and extended maintenance, respectively, was 52.1% (range, 50% to 58.3%), 35.4% (range, 25% to 41.6%), 12.5% (range, 0% to 25%), and 3.8% (range, 0% to 10.5%) for Mark; 83.3% (range, 75% to 91.7%), 45.3% (range, 41.6% to 50%), 12.5% (range, 0% to 25%), and 6.6% (range, 0% to 15.8%) for Bob; and 100%, 70.8% (range, 50% to 83.3%), 68.8% (range, 58.3% to 75%), and 24.9% (range, 0% to 36.8%) for Danny.

The social validity outcomes reported in Table 3 corroborate the data reported in Figure 1. Prior to treatment, staff members reported, on average, that they were moderately afraid to take the residents shopping, they had low to moderate levels of confidence that they could manage a resident in the store, and that the residents' problem behavior in the store was very severe. By the end of maintenance, they reported little or no fear of taking the residents shopping, high levels of confidence, and that problem behavior was almost never severe.

The posttreatment reports of the supermarket cashiers (Table 4) provided another measure of social validity. The cashiers noted, on average, little or no fear of the residents' behavior and strongly agreed that it was all right for the residents to shop in the supermarket.

DISCUSSION

Following a multicomponent treatment intervention, all 3 residents were able to complete a shopping expedition in the community with virtually no problem behavior. These positive results were achieved after a short period of training that varied from approximately 1 hr to 1.5 hr for each resident. The two dependent measures used to monitor progress (percentage of steps completed and latency) proved to be sensitive, stable indicators of intervention efficacy and changed lawfully as a function of treatment conditions. The positive outcomes reported in Figure 1 were further corroborated by the social validity data shown in Tables 3 and 4. Specifically, by the end of the study, the group-home staff members and the supermarket cashiers reported almost no fear of the residents' behavior, considerable confidence in being able to deal with any behavior difficulties (staff data), a perception that problem behavior was no longer severe (staff data), and full acceptance of the residents as supermarket patrons (cashiers' data).

The focus of the present study was on producing a desirable treatment outcome (i.e., completion of shopping without significant problem behavior) rather than on determining which elements of the multicomponent intervention were necessary and which were not. It may be that some other combination of treatments would have been equally (or more) efficacious. For present purposes, however, it is sufficient to note that the package did produce a positive outcome, that each element of the pack-

age had an empirical or clinical basis as reported in the published literature, and that each element was logically linked to the hypothesis-driven strategy articulated in Table 2.

Although a given hypothesis could lead to more than one plausible treatment, the number of plausible treatments is not without limits. Thus, if a tangible reinforcement hypothesis is posited, then communication training would focus on teaching the individual to request a specific item. Teaching the individual to request a break or social contact would not be plausible treatments in this case. Second, treatment selection depends not only on a recognition of the maintaining reinforcers but also on the specific details of the context in which the problem behavior occurs and the practical constraints under which the treatment agent must operate. Thus, in the first problem situation described for Mark (escape from the store), escape communication training was a plausible treatment but was not a practical one. If staff had taught Mark to request leaving the store, he would surely have mastered the skill; however, no shopping would have occurred. If staff had told Mark that they would honor his request but only after some shopping was accomplished, he would have aggressed toward the staff or other customers. Choice of initial activity was deemed the more practical intervention because it resulted in Mark's immediate engagement in nonproblem behavior in the context of store-related activities, thereby paving the way for the continuation of the shopping expedition. In sum, as noted earlier, the systematic delineation of decision rules for intervention selection in real-life contexts is an empirical question that rests on comparative treatment analyses as well as on practical considerations that are dictated by the specific details of the identified problem situation. Ultimately, general decision rules must be abstracted from programmatic research efforts rather than a priori assumptions made in individual studies.

The major goal of the present study, fully achieved, was to get residents who had been completely excluded from shopping in the community to be able to complete a supermarket expedition without exhibiting the severe problem behavior that had led to their exclusion in the first place. In contrast, as noted earlier, the major goal of previous studies was the development of independent shopping skills (Aeschleman & Schladenhauffen, 1984; Gaule et al., 1985; McDonnell, 1987; Wheeler et al., 1980). Because the participants in these earlier studies exhibited few, if any, problem behaviors, remediation was not required, and the interventions emphasized the teaching of specific shopping skills that were eventually displayed independently of staff support. Notwithstanding the need, in the present study, to focus on the remediation of severe problem behaviors as a first priority, we were able to demonstrate, as the study progressed from baseline through maintenance, a replicable pattern of increasing independence from prompts (i.e., decreasing use of corrective feedback, gestures, and physical assistance). The rapid acquisition of the task components suggests that the individuals already had most of the skills in their repertoires and that problem behavior functioned to interfere with the performance of those skills. If so, then the focus on reduction of problem behavior was especially appropriate. Indeed, by the end of the study, the shopping behavior of the 3 residents was primarily under the control of natural nonverbal and verbal cues that the staff members used routinely with the nonproblem residents with whom they went shopping.

Research in the community poses certain measurement challenges not typically found in more controlled environments. Laboratory analogue situations as well as more private settings (such as the home) permit the use of extensive videotaping and consequently the ability to record and evaluate large numbers of dependent and independent variables. In contrast, in a public setting such as a supermarket, our experience has been that the use of videorecorders is embarrassing for the staff, socially stigmatizing for the residents, and intrusive with respect to other store patrons who implicitly are expected to avoid blocking the camera view. Thus, we had to make strategic decisions concerning which variables were most worth recording, because it was not feasible to evaluate large numbers of measures through direct observation. Our decision

to limit recording to steps completed, latency, and amount of prompting was justified by the fact that these variables proved sensitive to the intervention procedures and were associated with acceptable levels of interobserver agreement.

Research in the community poses assessment challenges not typically found in more controlled settings. Optimally, one should begin an intervention by first carrying out a thorough functional analysis and then using the results of this analysis to guide treatment selection (Bailey & Pyles, 1989; Carr, Robinson, & Palumbo, 1990; Durand & Crimmins, 1988; Foxx, 1990; Iwata, Dorsey, Slifer, Bauman, & Richman, 1982; O'Neill, Horner, Albin, Storey, & Sprague, 1990; Wacker et al., 1990). However, in community settings, problem behaviors are frequently determined by multiple variables (Wacker, Northup, & Kelly, in press), thereby making multiple assessments necessary. In the present study, for instance, we identified 18 situations (Table 2) that were correlated with problem behavior. The cost of carrying out 18 separate functional analyses would have been prohibitive in terms of time and personnel. More seriously, carrying out multiple functional analyses in the store environment itself was impractical because of the resulting disruption and our likely expulsion from the store by supermarket management. In light of these difficulties, we opted for an hypothesis-driven model (Repp et al., 1988). Of course, this model was viable only because of extensive prior functional analyses carried out by many investigators over the years (see Carr, Robinson, Taylor, & Carlson, 1990, for a summary). That is, an hypothesis-driven model is not a substitute for functional analysis; rather, it is dependent upon a history of such analyses. Clinicians familiar with this research literature are probably more likely to deduce the same hypotheses compared to those not familiar with the literature. Thus, formal education in applied behavior analysis is a probable prerequisite for replicating the hypothesis-generation procedures that we have described. Hypothesis generation was also aided by two other factors. First, initial interviews with staff members conducted prior to baseline focused our attention on escape and tangible reinforcement as likely maintaining variables. Second, the level of specificity in the description of the problem situation was important in formulating hypotheses. The use of multiple sources of input (i.e., staff interviews and direct baseline observation) as well as provision of specific details in the baseline description are major factors that can facilitate the replicability of hypothesis generation.

The boundary conditions and pertinent parameters for successful treatment in the community have yet to be fully articulated in the research literature. The present study makes clear, however, that a multicomponent treatment intervention for severe problem behavior can be effective across a range of situations commonly found in a public setting. Further, one need not eschew such investigations because of the impracticality of carrying out multiple functional analyses. An hypothesis-driven model may be a useful alternative. It is also important to note that the limitations of traditional frequency and time-sampling measurement in public places need not deter researchers from carrying out interventions in these settings. Latency and task completion measures can be sensitive indicators of behavior change. The use of these measures keeps public embarrassment and disruption to a minimum. Therefore, the assessment and intervention model delineated in the present study may also be beneficial in dealing with severe problem behaviors in a variety of other public settings, such as restaurants, movie theaters, and shopping malls. By extending applied behavior analysis of problem behavior into these settings, we may be able to enhance the quality of living for people whose opportunities for community involvement would otherwise be severely limited.

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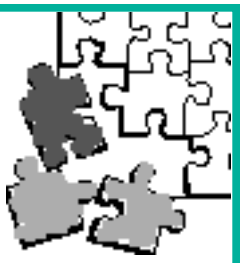


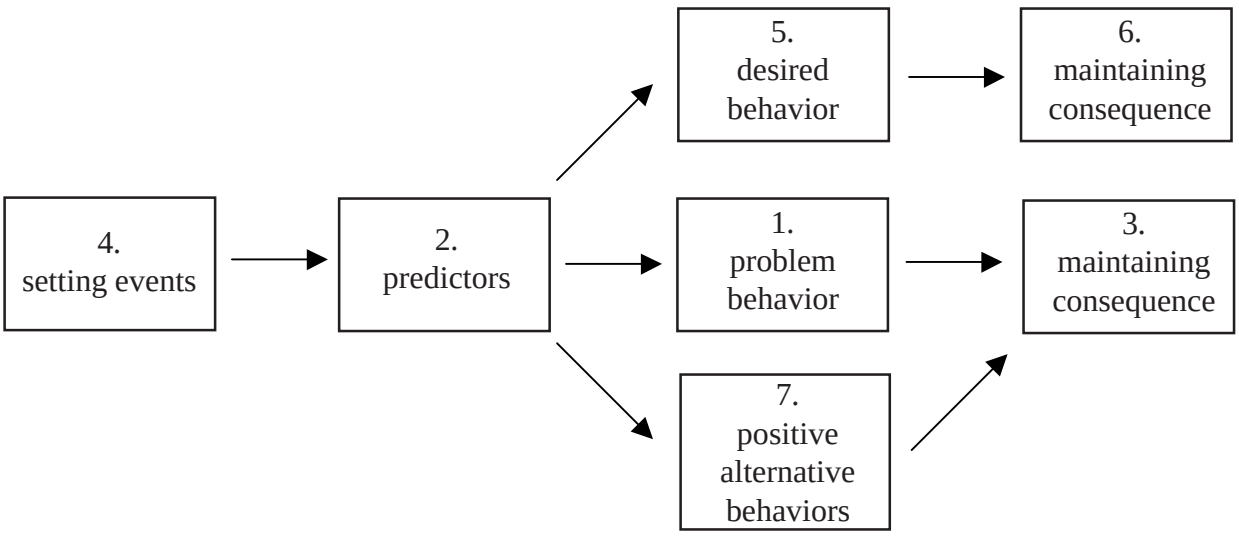
PBS Practice

The purpose of the series on PBS Practices is to provide information about important elements of positive behavior support. PBS Practices are not specific recommendations for implementation, and they should always be considered within the larger context of planning, assessment and comprehensive support.

Competing Behavior Model

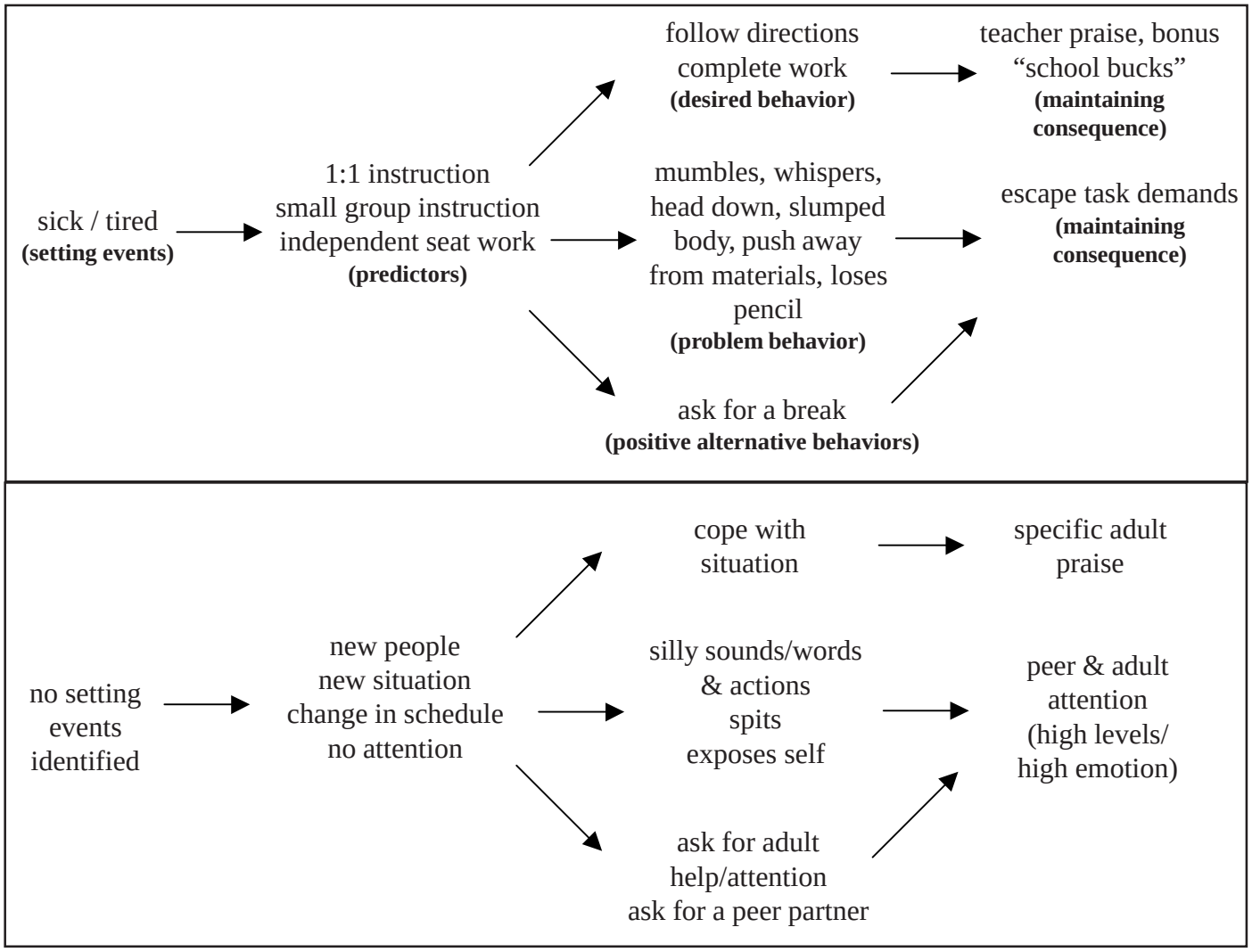
The competing behavior model helps to provide a link between functional assessment information and developing a positive behavioral support plan. This model is based on the logic that many different behaviors, some more appropriate than others, may serve the same function (i.e., produce the same reinforcing event). When a positive alternative behavior (i.e., a replacement skill) provides the same type of consequence that problem behaviors produce, the likelihood that a person will use the alternative behavior increases. This is especially true if the positive alternative is easier, or somehow more efficient, than problem behaviors. The problem behaviors are replaced by alternatives that successfully compete.

The competing behavior model involves seven steps. The first four steps represent a four-part summary statement (or hypothesis) that results from a functional behavioral assessment (FA). These first four parts are: (1) the **problem behaviors**, (2) **predictor events** (immediate antecedents) for problem behaviors, (3) the **maintaining consequence** of problem behaviors, and (4) **setting events** relevant to occurrence of problem behaviors. Once these core elements of the FA summary statement are identified, support planners should determine (5) the **desired behavior** in the situation (i.e., what behavior(s) do you really want the person to do?) and (6) the **maintaining consequence** for the desired behavior. Typically, the desired behavior leads to a maintaining consequence that is different from the consequence produced by problem behavior. Finally, they select (7) a **positive alternative behavior** (replacement skill) that will produce the same maintaining consequence as problem behavior. These seven parts result in a diagram (see below) that is then used for identifying and selecting possible behavior support procedures.



The basic idea in developing a support plan based on the competing behaviors model is to make problem behaviors irrelevant (there is no need to do them), inefficient (there are easier behaviors to engage in), or ineffective (problem behaviors no longer work to produce the desired outcome). Support planners identify procedures that will promote and strengthen the links between predictors, positive desired and alternative behaviors, and their maintaining consequences, and procedures that reduce or weaken the links between predictors, problem behaviors, and their maintaining consequences. To promote performance of desired behaviors, support planners must ensure that these behaviors have been taught, and that they produce adequate maintaining consequences (reinforcers) when they occur. To increase the use of positive alternative behaviors, an acceptable replacement behavior must first be identified, and then systematically taught. When this positive alternative behavior occurs, it must produce the same consequence that maintains the problem behaviors. To compete successfully with problem behavior, the positive alternative behavior must be more efficient in producing the desired maintaining consequence than the problem behaviors that it is replacing.

Examples:



Competing Behavior Model

Frequently asked questions:

1. Can a person have more than one problem behavior summary statement, and, therefore, need more than one competing behavior model developed? Yes. A competing behavior model should be completed for each summary statement that results from the functional assessment.

2. What if we do not know the setting events? Behavior support planning can still occur and be effective if relevant setting events are not known. Typically, connections with the individual's personal life help to identify relevant setting events for a problem behavior. Observations across living settings, and conversations with people who know the person with problem behavior well, may help to identify and understand the setting events that may contribute to the person's problem behaviors.

3. What is the difference between desired and positive alternative behaviors? Aren't they both just appropriate, positive behaviors? The main difference is in the consequences that these behaviors produce (i.e., their maintaining consequences). The maintaining consequences delivered for "desired behavior" are different from the consequences that maintain problem behavior. Because they produce different consequences, desired behaviors successfully compete with problem behaviors only when the consequences for desired behaviors are stronger (more powerful) than the consequences for problem behaviors. Positive alternative behaviors should result in the same maintaining consequences as problem behaviors. Because they produce the same consequences, alternative behaviors serve as acceptable replacement behaviors for problem behaviors. Alternative behaviors will be used if they are easier to do or more efficient than problem behaviors.

4. Does using the competing behaviors model to identify positive alternative behaviors guarantee that problem behaviors will disappear for good? No. First remember that you may need to teach and prompt an alternative behavior to get it to occur and be reinforced. Also, if alternative behavior does not work or stops working (i.e., is no longer reinforced), then problem behaviors may return, especially if they continue to produce desired outcomes for the person.

Other resources:

Horner, R. H., Albin, R. W., Sprague, J. R., & Todd, A. W. (2000). Positive behavior support. In M. E. Snell & F. Brown (Eds.), Instruction of students with severe disabilities (5th Edition) (pp. 207-243). Upper Saddle River, NJ: Prentice-Hall.

Horner, R. H., Sugai, G., Todd, A. W., & Lewis-Palmer, T. (2000). Elements of behavior support plans: A technical brief. Exceptionality, 8(3), 205-216.

O'Neill, R. E., Horner, R. H., Albin, R. W., Sprague, J. R., Storey, K., & Newton, J. S. (1997). Functional assessment and program development for problem behavior: A practical handbook. Pacific Grove, CA: Brooks/Cole.

What is Positive Behavior Support?

Positive behavior support (PBS) involves the changing situations and events that people with problem behaviors experience in order to reduce the likelihood that problem behaviors will occur and increase social, personal, and professional quality in their lives. It is an approach that blends values about the rights of people with and without disabilities with a practical science about how learning and behavior change occur. PBS is 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, defiance, and disruption. The overriding goal of PBS is to enhance quality of life for individuals and others within social settings in home, school, and community settings.

Research evaluating the effectiveness of positive behavior support began in the field of developmental disabilities with both children and adults living at home and in community settings. These researchers were interested in whether PBS could be an approach that may improve an individual's quality of life and reduce the incidences of problem behavior. Important characteristics of PBS include:

- Person centered planning
- Collaborative teaming
- Functional behavior assessment
- Hypothesis development
- Multi-component planning
- Evaluation
- Systems change

Originally, many positive behavior support interventions were evaluated using single subject designs or case studies. Single subject designs and case studies usually involve a smaller number of individuals being studied as opposed to a large number of study participants participating in a group experimental design. Single subject designs and case studies usually involve a smaller number of individuals being studied as opposed to large numbers participating in a group experimental design. The more examples of individual studies describing successful interventions with a wide range of children and adults, the greater the evidence over time that the results of PBS may be a widely successful approach.

In 1999, Carr and his colleagues published a synthesis of research in positive behavior support. This monograph provided evidence that positive behavior support is an effective approach for reducing challenging behavior and increasing quality of life for individuals with developmental disabilities.

- Carr, E.G., Horner, R.H., Turnbull, A.P., Marquis, J.G., Magito McLaughlin, D.McAtee, M.L., Smith, C.E., Anderson Ryan, K., Ruef, M.B., & Doolabh, A. (1999). *Positive behavior support for people with developmental disabilities: Research synthesis*

(American Association on Mental Retardation Monograph Series). Washington, D.C.: American Association on Mental Retardation.

Many of the studies included in this monograph referred to research published in the *Journal of Applied Behavior Analysis*. In fact, positive behavior support exists today because of the hard work and talent of professionals in the field of applied behavior analysis (ABA). For instance, research in the area of functional behavioral assessment, one of the cornerstones of the PBS process, was developed based upon ABA research.

Functional Behavioral Assessment

The cornerstone of PBS is the design and use of functional behavioral assessment to understand what reliably predicts and maintains an individual's problem behavior. Individuals engage in a behavior because it is functional; it helps them acquire some form of reinforcement (e.g., they get something desirable or pleasant, or they avoid something undesirable or unpleasant). A person may engage in problem behavior because circumstances in both the internal and/or external environment (i.e., antecedents, setting events) trigger or 'set the stage' for behavior to occur. Functional assessment is a process for identifying the events that trigger and maintain problem behavior. This process involves information gathering through record reviews, interviews, and observations and the development of summary statements that describe the patterns identified. Primary outcomes of the functional assessment process include:

- A clear description of the problem behaviors
- Events, times, and situations that predict when behaviors will and will not occur (i.e., setting events)
- Consequences that maintain the problem behaviors (the function)
- Summary statements or hypotheses
- Direct observation data to support the hypotheses

Individualized Interventions

The team that forms around a child or adult in order to create a PBS plan should represent all of the situations and settings that are part of the person's life. Information that is gathered from a functional behavioral assessment helps the team develop and implement behavioral intervention plans that are *positive, proactive, educative, and functional.* PBS plans include a number of interventions that can be implemented across situations and settings. These interventions include: 1) proactive strategies for changing the environment so triggering events are removed, 2) teaching new skills that replace problem behaviors, 3) eliminating or minimizing natural reinforcement for problem behavior, and 4) maximizing clear reinforcement for appropriate behavior. Many of the interventions used in PBS were first validated in research studies published in the *Journal of Applied Behavior Analysis*.

Lifestyle Enhancement

A hallmark of PBS planning is its emphasis on improving overall lifestyle quality (relationships, activities, health) as an integrated part of behavior support. PBS focuses not only on reducing

behavior problems, but on enhancing a person's overall quality of life. Outcomes include lifestyle improvements such as participation in community life, gaining and maintaining satisfying relationships, expressing personal preferences and making choices, and developing personal competencies. Such improvements in quality of life are facilitated by establishing a positive long-range vision with the individual and his/her family (e.g., through person-centered planning) and establishing natural supports through effective teamwork.

Person-centered Planning and Wraparound

Wraparound and person-centered planning (PCP) are two strategies that can be used to facilitate team-based plans for improving a child or adult's quality of life as defined by the child or adult, his or her family, and other members of the community. Although wraparound and PCP have some similarities, they originated to support different populations of people (individuals with emotional and behavioral disorders and individuals with developmental disabilities).

Wraparound is a team-based planning process that is led by an individual and family. The wraparound process results in a tailored and individualized set of supports services and interventions that result in an increase in positive lifestyle outcomes. In particular, wraparound has been a valuable process for supporting children and adolescents with emotional and behavioral problems. A comprehensive wraparound plan addresses needs defined by the child and parents, and those closest to them (i.e., family, friends, and teachers) with a particular emphasis on building upon a child's strengths. Family members are considered full and active partners in the process Although behavior and academic interventions are often included, wraparound plans are more comprehensive because multiple life domains (i.e. medical, basic needs, safety, cultural, spiritual, etc.) and settings (i.e. home, school, community) are addressed.

Person-centered planning (PCP) strategies were developed to support children and adults with developmental disabilities so that they are actively involved in defining lifestyle preferences and personal goals. The PCP process is also a team-based process that results in ongoing problem-solving meetings with a group of people who are interested in helping the child or adult achieve a lifestyle based upon his or her preferences, needs, and choices. The purpose of a PCP is to build a context in which a student can create a vision for how he or she wants to live, and to brainstorm, strategize, and plan to make that vision a reality (Flannery et al., 2000).

Future Research

A clear need outlined in Carr's 1999 AAMR monograph synthesizing research in the field was the need for more research on issues related to PBS and issues related to lifestyle enhancement. Few of the studies reported in the AAMR synthesis reported data on quality of life changes or other social validity evaluations to indicate how well the interventions fit the values, resources, and skills of the individuals who would need to implement those interventions on a long term basis. Many studies within the literature were time limited and did not address critical issues related to sustainability. Tensions naturally exist in the research field between the need to establish clear methodological rigor and to demonstrate that PBS can be implemented in natural settings with family members, teachers, and other individuals where it can be difficult to control all of the variables that may contribute to behavior.

This concern led to the establishment of a journal dedicated to positive behavior support. The *Journal of Positive Behavior Interventions* is the first journal dedicated to positive behavior support research.

The research field of PBS remains exciting and vibrant. Research is now tackling the issues set forth by the Carr monograph and other critics. One exciting area of research is on systems change in educational settings.

PBS Research and Systems Change

Part of the definition of PBS includes the importance of considering the larger systems in which PBS is being implemented. Examples of systems issues may include the values and mission of a school or organization, the level of administrative support and attention is given to PBS planning, how easily fiscal resources can be allocated to support implementation efforts, and policy and procedures supporting PBS training and technical assistance. These issues are critically important in order to create an effective PBS plan that will be sustainable and contextually appropriate for a child or adult receiving support.

School-wide PBS is implemented systematically so that all students benefit by learning social skills and experiencing positive school settings. School staff work together to ensure everyone responds consistently to the occurrence of problem behavior and use data to identify areas of the school that may need more intensive interventions. Data are also used to identify students in need of more intensive supports based on each child's needs. Researchers are focusing on determining whether implementing large scale implementation of PBS at statewide, district-wide, and school-wide implementation levels are being successful.

Researchers are now focusing on larger systems-level changes for systematically implementing large scale implementation of PBS at statewide, district-wide, and school-wide implementation levels. Researchers are currently evaluating the effectiveness of the school-wide PBS model.

Other organizations can benefit from the school-wide PBS model by adapting the same types of outcomes, systems, and data based decision-making processes to the unique services provided. More research is needed in states, schools, and other organizations to demonstrate how to implement PBS in ways that are sustainable across time and in diverse situations and settings.

Reference

- Fixen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (Louis de la Parte Florida Mental Health Institute Publication No. 231). Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute. National Implementation Research Network.

Positive Behavior Support Stories

Student, Young Adult, and Adult Examples

PBS Stories

Young Adult and Older Adult PBS Plans

About Alex

Alex is a sophomore at Red Rock High School. He is a student with high functioning autism. He uses sign language, the computer, and a Dynavox augmentative communication device to communicate. His current schedule is:

Language Arts 10
World History
Physical Education
Health
Biology
Algebra
Graphics Technology

Alex does well in school much of the time. He is expected to pursue college or community college after he finishes high school. A major concern for the team is that Alex struggles to remain calm when he feels his work will not be completed on time. When he is upset, he tips over desks, yells, and leaves school grounds. He is currently completing 50 % of the work in Language Arts.

Alex's High School

Red Rock High School is in the second year of school-wide positive behavior support implementation. The school's three school-wide rules are: "Respect ourselves and others," "Education comes first," and "Dedication to our goals is paramount". Other universal supports available to all students include homework posted on the school website, tutoring before school, and social work/counseling support, as needed.

In addition to these general supports, there are also more targeted supports in place for Alex. He has a circle of friends that is supported by the social worker. This group gets together twice a week at lunch independently with the social worker engaging the group once every six weeks. Alex also has drop in meetings with the one of the vice principals to discuss social concerns he has. This has been very effective in the past in mediating confusion about social situations. Recently, Alex has been referred for individual social work support for depression. This has been going well.

To address the specific behavioral concerns that Alex exhibits when he feels his work will not be completed on time, Alex's IEP team (including the parents and Alex) agree that he needs a positive behavior support plan in addition to the school-wide supports available to him.

Understanding Alex's Behavior

Alex's special education teacher and the parents took the lead in suggesting that the team complete a PATH for Alex. As a part of this planning process, Alex indicated he would head for college at age 21, taking advantage of the transition process available at the high school. He would like to take computer tech classes in college. Alex's parents stated that he was likely to either continue to live with them or receive live-in support in his own apartment during the rest of high school and into college. Through the discussion of Alex's dream for his future and goals generated in the PATH process, the staff supporting Alex in the high school reported that they understood him better and felt more unified in what they were doing.

A functional behavior assessment was conducted to determine the stressors associated with Alex's outbursts. One interesting finding was that Alex's degree of concern and level of discomfort varied depending on the class. It also appeared that Alex acted out for attention as opposed to acting out to escape the situation. The team hypothesized that the pressure was increased for Alex in subjects that he took pride in (Science and Language Arts), rather than for math or electives. A competing pathways model was used to determine setting events, antecedents, replacement behaviors, and alternate behaviors for Alex. Based on this information, a multi-component plan was developed to address Alex's stress around deadlines.

Designing Strategies for Alex

The replacement behavior for tipping desks, yelling and leaving school grounds was to inform a trusted person (to be identified by Alex) and develop a plan for extending the timeline for the assignment. During this process, it became clear to the team that Alex would need some skills development in order to accomplish this. Alternate behaviors that resulted in the same outcome (increased attention to Alex, so that he could vent and plan) were also developed. Alex can use a break card when he realizes he is stressed out. He can also go to the counseling office and talk with someone about what is bothering him.

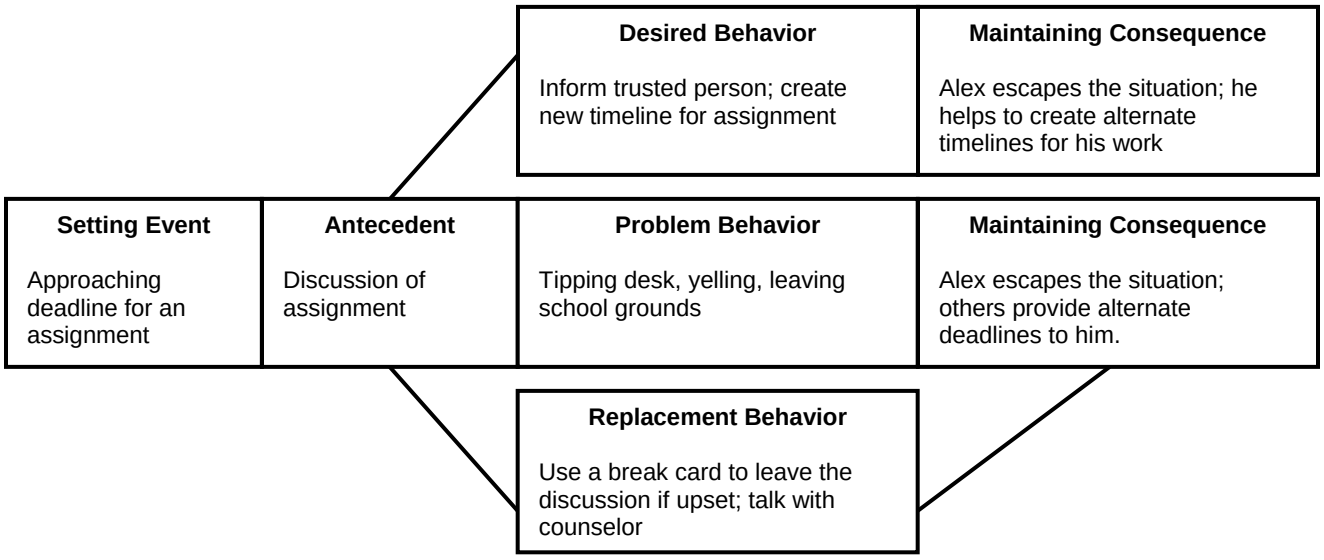
The team then realized that Alex may not recognize all of the signals that his body sends that he is stressed. By having his support person and teachers learn these signals, the staff can cue Alex as he is learning them himself. In addition, the team also addressed the setting events and antecedents that precede problem behavior.

Is the Plan Working?

After one month of taking data on the support plan, Alex was having significantly more time in class without leaving because he was upset. After three months, the Language Arts teacher reported that he was completing 25 % more of his assignments and was maintaining a passing grade. In addition, Alex's parents reported at the plan evaluation meeting that Alex was also less stressed at home and more able to complete his assignments.

Click Here to See an Example of Alex's Brainstorming Session

Alex's PBS Brainstorming Session Process



Setting Event	Antecedent	Problem Behavior	Consequence
Approaching deadline for an assignment	Discussion of assignment	Tipping desk, yelling, leaving school grounds	Alex escapes the situation; others provide alternate deadlines to him.
Setting Event Interventions	**Antecedent Interventions**	**Replacement Behavior & Other Related Social and Communication Skills**	**Consequence Interventions**
Reminders of assignment deadlines Teacher check in the week before assignment is due	Learn body signals of stress Create and teach break card use	Inform trusted person; create new timeline for assignment Alex can take a break if stressed by the conversation Identify trusted person Create timeline adjustment process with teachers	Alex knows when he is upset and needs to seek support Alex chooses to take a break when he needs one Alex chooses his new timelines Alex can complete his work and see himself as capable

Adapted from O'Neill, R. E., Horner, R. H., Albin, R. W., Sprague, J. R., Storey, K., & Newton, J. S. (1997). Functional assessment and program development for problem behavior.

Individual Support Examples in the Community

About Gil

Gil is an adult with Down syndrome. He lives with his mother and her sister, his Aunt Georgia. He has a twenty-five hour a week job at the local supermarket as a stocker and bagger. He also makes and sells beads at his aunt's booth at the flea market. When Gil does not understand what is being asked of him, he will run and hide under objects or furniture. Earlier this year, there was a bomb threat at the supermarket. Gil hid under a car in the parking lot. Since that time, when asked to do things outside the typical routine of the day, Gil repeats this behavior. Gil's Aunt Georgia has suggested a PBS plan to his mother. They requested PBS from Gil's case manager.

Understanding Gil's Behavior

Gil's case manager brought together Gil's mother and aunt, his supervisor and a co-worker, and friends of Gil's from the flea market to conduct a person centered plan and a functional behavior assessment as part of the PBS process. The person centered plan revealed that Gil's life has been consistently structured and oriented to routines. In the part of the plan that addressed Gil's dreams and fears for the future, he made it clear that he was very afraid of losing his job. He became upset when the topic of the meeting shifted to his need to hide and asked everyone to leave. He and the team agreed to reconvene the next week. Gil also agreed that team members could observe at the job site and talk with each other and with him before the next meeting. When the team reconvened they completed the person-centered plan as well as began discussing the functional behavior assessment.

The functional behavior assessment indicated that Gil left the store and hid in the parking lot more often on days when his break was in the afternoon than when his break was at 10:30 in the morning. The team suggested a set time of 10:30 for Gil's break. He also had less difficulty when Stan is the manager than when Collette was the manager. When discussing this observation from the functional behavior assessment, Collette explained that she writes down changes in the routine that affect Gil and discusses this with him after the meeting. The team agreed that this could assist Gil. The functional behavior assessment also indicated that Gil feels safe when he hides. The team agreed that if Gil could let the staff know he was leaving the meeting and why, he could wait in the staff lounge and get information on changes that affected him after the meeting.

Designing Strategies for Gil

In addition to the ideas discussed as a part of the functional behavior assessment, the team also discussed the past use and success of transition objects. Gil's mother bought some small pocket items for the managers and employees to give to Gil to hold on to when changes in routine were discussed. This has assisted in Gil being able to listen to directions longer and here full descriptions of what is happening. In addition, the team brainstormed ways to teach Gil to ask for

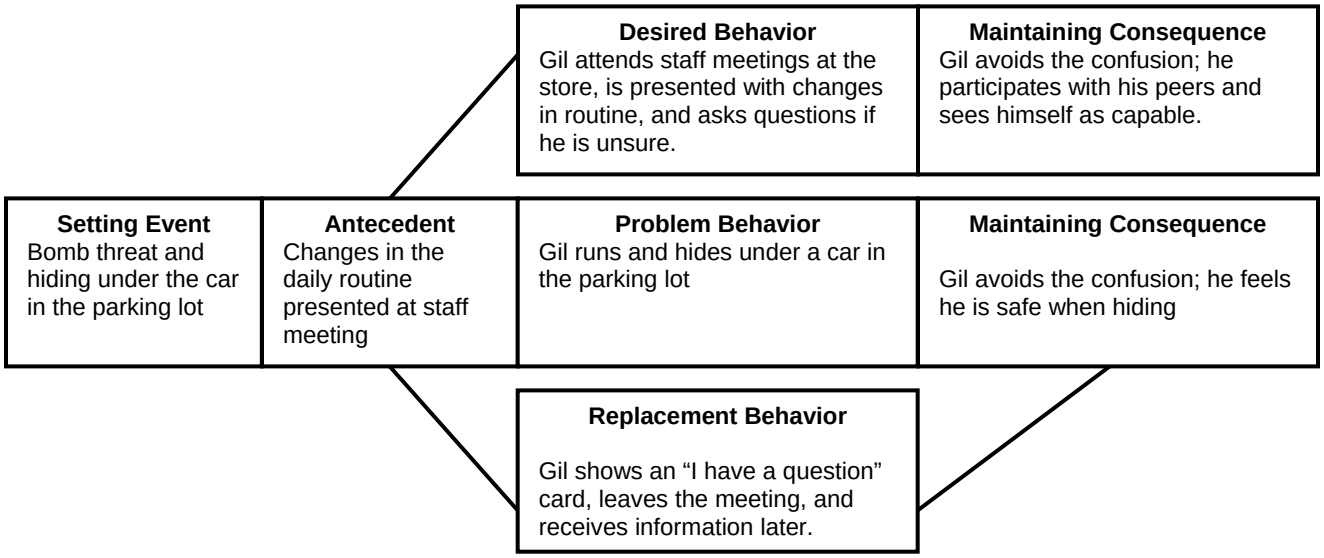
clarification. Gil suggested an “I have a question” card that he could show to the managers in meetings before he leaves. Gil can then take a break and the rest of the information is shared with him one-on-one. In situations when he feels very uncomfortable, Gil uses a cell phone to call his mother or aunt.

Is the Plan Working?

Since these strategies have been in use, Gil has hidden in the break room one time and gone into the parking lot only twice. Both times, Gil has been able to come back into the store without going underneath cars. The team is currently satisfied with the progress seen from the plan.

Click Here to See an Example of Gil’s Brainstorming Session Results

Gil's Brainstorming Session Results



Setting Event	Antecedent	Problem Behavior	Consequence
Bomb threat and hiding under the car in the parking lot	Changes in the routine of the day presented at staff meeting	Gil runs and hides under a car in the parking lot	Gil avoids the confusion; he feels he is safe when hiding
Setting Event Interventions	**Antecedent Interventions**	**Replacement Behavior & Other Related Social and Communication Skills**	**Consequence Interventions**
Reassure Gil that the bomb threat was a very unusual event and that it is over	Notify Gil of changes before the staff meeting Create "I have a question" card Teach Gil how his body indicates stress Write down changes and present them to Gil outside the staff meeting	Gil shows the "I have a question" card and leaves the meeting to be in the staff lounge, and receives his information later one-on-one	Gil avoids the confusion; he participates with his peers and sees himself as capable.

Adapted from O'Neill, R. E., Horner, R. H., Albin, R. W., Sprague, J. R., Storey, K., & Newton, J. S. (1997). Functional assessment and program development for problem behavior.

PBS Stories

School Examples of PBS Plans

Selena

About Selena

Selena is a second grader at Feather Plume Elementary School. She has a seizure disorder, cerebral palsy, and a shunt. She had a stroke at birth, in addition to the anoxia that contributed to her Cerebral Palsy. She uses speech to communicate, but often depends on scripted language to communicate effectively. She does not like to be touched and is resistant to eating. In the cafeteria, Selena screams loudly if people try to encourage her to eat. She spits and hits people if offered food is near her. She also takes a long time to eat. Her educational team is concerned because she has continued to lose weight over the past year. When presented with schoolwork, Selena tantrums and continues to tantrum until she is removed from the activity. In addition, she is perceived to be disruptive by her peers. As a result of these concerns, the team created a PBS plan to address Selena's needs.

Selena's Elementary School

The school is implementing a school-wide PBS model. Feather Plume's schoolwide expectations are: Fairness, Pride, Education, and Service; Fairness for all, Pride in what we do, Education for everyone, and Service to each other. Since the inception of school-wide positive behavior support at Feather Plume Elementary, office discipline referrals have dropped from 60 per month to 22 per month and teachers report a greater sense of satisfaction with the school. Selena has just started attending the school's after-hours program as a part of more tailored school-based interventions. She seems to enjoy the activity.

Understanding Selena's Behavior

Selena's educational team conducted a person-centered plan and a functional behavior assessment as part of the PBS process. During the person-centered plan, Selena's mother stated she felt that Selena's lack of desire to eat was rooted in her need to control her environment. She believes that choosing not to eat is the one way Selena can consistently exert control. Her mother also explained that early in her life Selena had had extensive one-on-one therapy that resulted in her becoming resistant to doing work. Her classroom teacher is worried that removing Selena from the classroom (and the activity) when she tantrums might be rewarding her for negative behavior.

The functional behavior assessment supported the discussion that occurred during the person centered plan. The staff and her family have been very concerned about Selena eating and lunchtime feels pressured. Selena sits with a staff member and is presented with individual bites

of food. Selena is also isolated from her peers. During lunch time, Selena refused any presentation of food by saying, “No, no, no,” or “All done.” Selena consistently screamed and hit herself and her wheelchair to avoid any work activity. She also appeared to be sensitive to going near desks or tables and began to say “No, no, no” when placed near either her desk or the table in the lunchroom. Based on this information, the team agreed that there were two main behaviors of concern and developed competing pathways to address each of them.

Designing Strategies for Selena

The first behavior of concern identified by the team during the functional behavior assessment was Selena’s refusal to eat at school. A setting event for this behavior is that Selena does not have many opportunities to make choices during the day. By increasing Selena’s opportunities to choose activities, she gains a greater sense of control. This may reduce the need for her to refuse food over time.

An antecedent to the behavior is that eating is presented as a task, rather than as a pleasant activity. One of the activities suggested during the person centered plan is that Selena really enjoys telling stories and jokes. The team created a Joke club that included her. The Joke club meets at lunchtime every day. The expectation is that, initially, Selena would come and listen to jokes. She could choose whether to eat or not, and the cafeteria would become a more pleasant place to go. As she is comfortable in the cafeteria at the table with her peers, then food would be presented in the hope that she would eat while participating with her peers (Her sister reported success with this strategy at home.)

In order to address the Selena’s refusal to work, the team agreed that Selena needed reassurance that school was a good place to be. With respect to the antecedent or trigger of being placed near a desk or table, the team agreed that work production was the priority and that the location where Selena did her work was flexible. Selena could choose to work in the library where there are more creative seating options (tipi, bathtub, bean ban chairs). The team also believes that Selena is inadvertently rewarded by being removed from the classroom when she tantrums. In order to help her sustain in the classroom, the team suggested the use of a break card, so that Selena can escape work while continuing to stay in the class with her peers. In addition, Selena’s desk was moved close to the window so that she can look out if she is feeling anxious about being in the room.

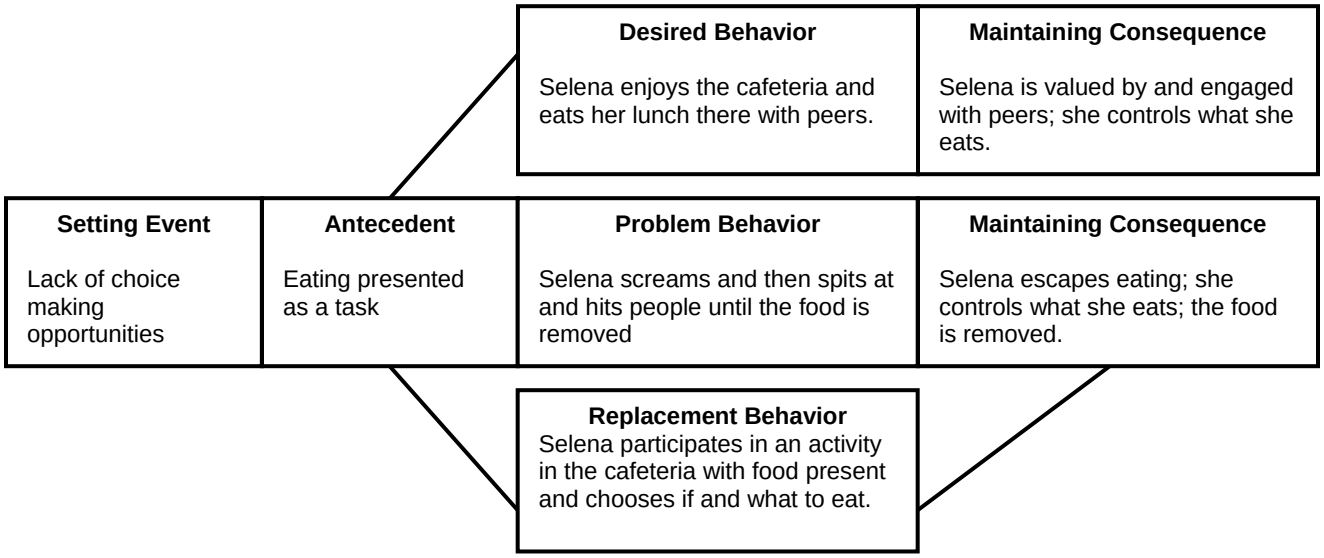
Is the Plan Working?

After one week of the Joke Club, Selena asked a fellow student for a potato chip and ate it. One month after Selena was going to the cafeteria daily, drinking milk there daily during Joke Club and eating at least one time a week. After one semester, Selena was eating between 2 and 3 times a week in the cafeteria, but going happily every day.

After one month, Selena was choosing daily to work in the library. She resisted completing work about one half of the time. She used the break card the other half of the time. After one semester, Selena was completing about 66 percent of her work and does about half of that in the library. The team will continue to monitor the plan to ensure Selena continues to make progress completing her work.

Click Here to See an Example of Selena’s Brainstorming Session Results for Both Behaviors of Concern

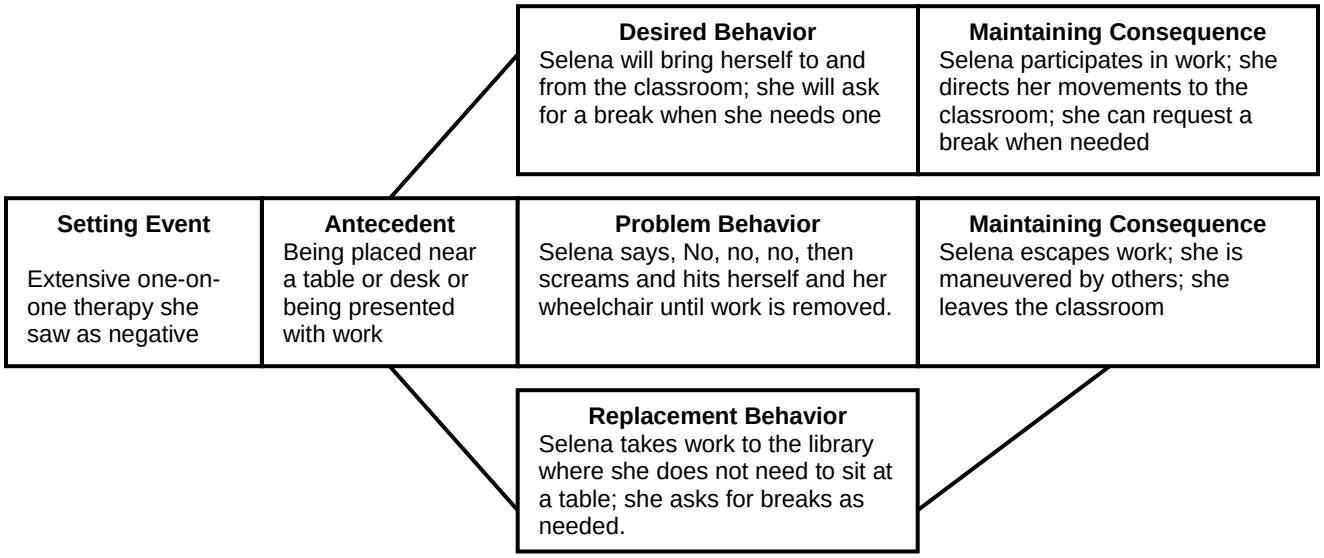
Selena's First Brainstorming Session Results



Setting Event	Antecedent	Problem Behavior	Consequence
Lack of choice making opportunities	Eating presented as a task	Selena screams, spits at, and hits people until the food is removed	Selena escapes eating; she controls what she eats; the food is removed.
Setting Event Interventions	**Antecedent Interventions**	**Replacement Behavior & Other Related Social and Communication Skills**	**Consequence Interventions**
Increase opportunities for Selena to choose activities and modes of work production in settings outside of eating environment	The cafeteria is presented as a fun place to be. Selena is not expected to eat. Selena spends time with peers rather than with staff A social activity is the basis of Selena's presence in the cafeteria; eating is incidental.	Selena participates in an activity in the cafeteria with food present and chooses if and what to eat.	Selena controls whether or not she eats.

Adapted from O'Neill, R. E., Horner, R. H., Albin, R. W., Sprague, J. R., Storey, K., & Newton, J. S. (1997). Functional assessment and program development for problem behavior.

Selena's Second Brainstorming Session Results



Setting Event	Antecedent	Problem Behavior	Consequence
Extensive one-on-one therapy she saw as negative	Being placed near a table or desk or being presented with work	Selena says, No, no, no, then screams and hits herself and her wheelchair until work is removed	Selena escapes work; she is maneuvered by others; she leaves the classroom
Setting Event Interventions	**Antecedent Interventions**	**Replacement Behavior & Other Related Social and Communication Skills**	**Consequence Interventions**
Present school as a positive place; reassure Selena that school is not like therapy Provide alternate ways to show work than showing compliance	Selena will direct her wheelchair. Staff will not place her near tables or desk without her direction. Selena selects where she would like to work; the classroom or the library. Selena will organize work tasks in the order she wishes to perform them.	Teach Selena to use a break card to ask to stop work. Selena will move her wheelchair away from the table and engage in a favored activity in the classroom She directs her own movements in the classroom	Selena organizes her work schedule and work location She takes breaks as needed when she asks for a break Avoid allowing escape when Selena self injures. Protect Selena from injury by blocking self injury and prompt request for break (next time prompt Selena to request a break before self injury whenever possible)

Adapted from O'Neill, R. E., Horner, R. H., Albin, R. W., Sprague, J. R., Storey, K., & Newton, J. S. (1997). Functional assessment and program development for problem behavior.

Sabrina

About Sabrina

Sabrina is a 7th grader at Junction Forks Middle School. When she was four years old, she was placed in foster care due to severe abuse and neglect. Since that time, she has lived with the same foster family. The family is now pursuing adoption. When Sabrina feels threatened, she bites herself and others. When she does not know what is expected in a situation, she feels threatened. Sabrina's school schedule is:

M, W, F	1st block -- Language Arts/Choir
T, Th	-- Homeroom/Computer
M,W,F	2nd block – PE/Art/Health
T, Th	-- Science/ Social Studies
M-F	3rd block – Lunch/Learning Lab
M, W, F	4th block – Mathematics
T,Th	Electives

Her favorite subjects are Science and Math. Her least favorite class, she says, is lunch. The team believes it is because she does less well with unstructured time.

Understanding Sabrina's Behavior

The team conducted a MAPS planning process and a functional behavior assessment as a part of the PBS process. Sabrina's MAPS indicated that her nightmare is that she would have no friends and that no one who really cares for her. She is both excited and nervous about being adopted. The functional behavior assessment revealed that Sabrina bites herself or others when she perceives a threat. Biting never occurs in Choir or Science. She consistently bites in every class other than Science at second block.

Designing Strategies for Sabrina

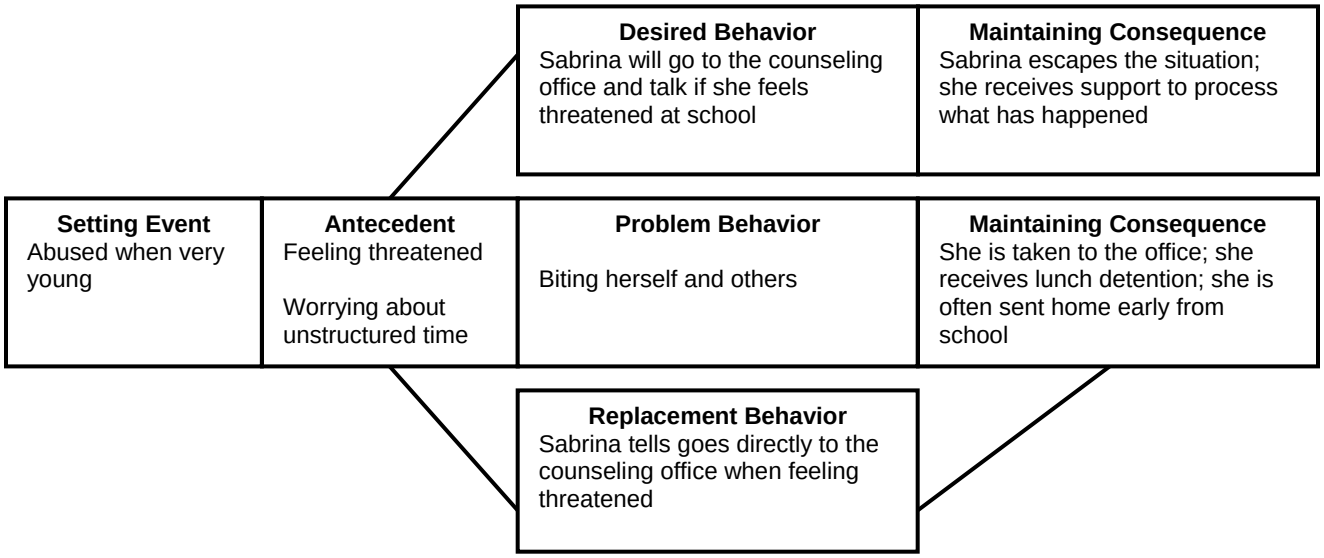
To reassure Sabrina that she is cared for, the team designed a scrapbook and photo albums of her friends and foster family that Sabrina can review. The team also identified feeling threatened as an antecedent to Sabrina's acting out. The team arranged for Sabrina to leave any environment she feels is threatening and to go to the counseling office, an environment Sabrina identifies as safe. The positive behavior support plan focused on changing Sabrina's activities at second block and at lunchtime. The team reduced the number of classes that Sabrina takes at second block. She is taking only PE or Art at this time now. At lunch time, she is a counseling office helper and eats her lunch in the counseling office with a small group while doing other activities.

In addition to working, she also has the opportunity to touch base with counselors if she needs to throughout the day.

Is the Plan Working?
Her foster mother reports that since the plan has been in effect (eight months), the calls from the school to pick up Sabrina have decreased from one time a week to one time a month. Sabrina has not been to the emergency room for bites in four months. Sabrina told her grandmother that middle school is better than it was last year. The team feels that they have a better understanding of Sabrina and her emotional needs.

Click here to see an example of Sabrina's Brainstorming Session Results

Sabrina's Brainstorming Session Results



Setting Event	Antecedent	Problem Behavior	Consequence
Abused when very young	Feeling threatened Worrying about unstructured time	Biting herself and others	She is taken to the office; she receives lunch detention; she is often sent home early from school
Setting Event Interventions	**Antecedent Interventions**	**Replacement Behavior & Other Related Social and Communication Skills**	**Consequence Interventions**
Sabrina reviews photo book of her history with her foster family.	Sabrina has permission to leave any environment that feels threatening to go to the counseling office Sabrina has a job in the counseling office over lunch (avoiding the chaos of the cafeteria). Sabrina has a reduced course load at the peak time of the day	Sabrina works as a counseling office aide, establishing both routine and relationships with counseling staff Sabrina learns to identify when she is feeling threatened and goes to the counseling office Sabrina develops a trusting relationship with counseling staff Sabrina learns problem solving skills	Sabrina still receives access to the office, but as a worker; she avoids lunch time without detention; she does not need to leave school for medical attention

Adapted from O'Neill, R. E., Horner, R. H., Albin, R. W., Sprague, J. R., Storey, K., & Newton, J. S. (1997). Functional assessment and program development for problem behavior.

Questions for assessments:

For person

What kind of things do you like to do?

What places do you like to go to?

What do you like to do with your friends?

What do you like to do with your family?

Do you have any other people in your life that you enjoy spending time with, or are important to you?

When someone is around you, how can they tell if you are happy…sad…upset?

What do you wish people knew about you when they are working with you?

What are some ways the people who help support you work with you? (Money management, self-care, household chores, cooking, helping with rights,,,)

What are some things people do that you like….Don't like?

What kind of music do you like....Don't like?

What kind of movies do you like… Don't like?

Is there anything you just don't like to do?

What kinds of food do you like… Don't Like?

Why do you want to attend this Service?

If you could do anything you want, what would it be?

What makes a good morning…bad morning?

What would be your ideal day?

What makes a bad day?

What do you like to do in the evening…weekend?

Do you have any hobbies?

What kind of staff works best with you?

Do you have any health concerns we need to be aware of or you need assistance with?

Do you have any safety concerns you would like your staff to be aware of or you need assistance with?

With current care provider/staff/family/TCRC

What would be some of the most important things you would tell a new staff person working with this individual?

Are there any nuances in working with this person that you have found to be particularly helpful? (i.e.: with their behaviors, with their likes, dislikes, with communication, etc.)

Are there any health concerns to be aware of?

Are there any safety concerns to be aware of (in home of in the community?)

Does the person need assistance with noon medication while at program?

Person Centred Planning

Person Centred Planning is a way of helping people to think about what they want now and in the future. It is about supporting people to plan their lives, work towards their goals and get the right support. It is a collection of tools and approaches based upon a set of shared values that can be used to plan *with* a person - not *for* them. Planning should build the person's circle of support and involve all the people who are important in that person's life.

Person Centred Planning is built on the values of inclusion and looks at what support a person needs to be included and involved in their community. Person centred approaches offer an alternative to traditional types of planning which are based upon the medical model of disability and which are set up to assess need, allocate services and make decisions *for* people.

The Tools

There are a number of tools for person centred planning. They all follow the below principles; the person is at the centre, family and friends are partners in planning, the plan focuses on gifts and capacities and looks to the future, planning builds a shared commitment to action, planning is an on-going process. Which tool we use depends upon the person and their life.

PATH

The PATH process was developed by Jack Pearpoint, Marsha Forrest and John O'Brien. It is a tool used to get people unstuck and create short and long term goals.

The focus person and other important people meet for 2-3 hours. The meeting is facilitated by two people. The **Process Facilitator** manages the process, by talking to the focus person and other people in the meeting. The **Graphic Facilitator** keeps a graphic record of the meeting which is owned by the person. The process has a number of steps that must be followed.

1. The dream
2. One year on
3. Now
4. Enrol
5. Growing stronger
6. Actions
7. First steps

PATH is a great tool to use when people feel 'stuck' or have a problem to solve.

MAPS

MAP is a style of planning developed by Marsha Forrest and Jack Pearpoint. It is a tool which builds a shared commitment to help the focus person move towards their dream and away from their nightmare.

The focus person and other important people meet for 2-3 hours. The meeting is facilitated by two people. The **Process Facilitator** manages the process, by talking to the focus person and other people in the meeting. The **Graphic Facilitator** keeps a graphic record of the meeting which is owned by the person. The process has eight steps which are flexible.

1. What is a MAP?
2. The story / background
3. The dream
4. The nightmare
5. Who is the person
6. What are the person's gifts
7. What does the person need
8. The action plan

MAP can be used when we want to learn from a person's past to help shape their future.

One Page Profiles and Living Descriptions

This tool was developed by Essential Lifestyle Planning Learning Community as a way to start finding out what is important to people in their everyday lives. One Page Plans provide a capacity description of a person focusing on what others like and admire about them, what's important to them and what we need to know or do to provide good support. One Page Plans develop into living descriptions as we learn more about people and record this information.

One page plans are developed by thinking about what we know about what's important to somebody and the support they need. Trained facilitators can help people think about how to build on a one page plan.

One page plans should include:

What we like and admire
What's important to a person
What support someone needs
What's working and not working
An action plan

Living Descriptions could include:

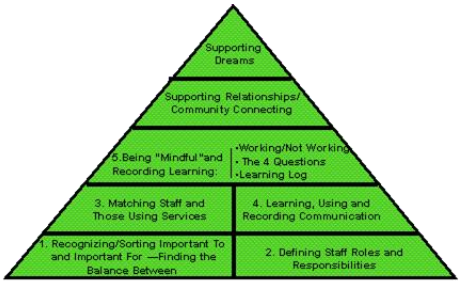
How to communicate with the person
Who supports the person best
Routines and rituals
Staff roles and responsibilities
Dreams
Decision making agreements
Health information
Relationship circle

One page plans and living descriptions are a useful tool to use when people receive paid support as they help staff to provide support in a way that works for the person.

Person Centred Approaches

Person Centred Approaches are ways organisations who support people use tools from person centred planning to ensure that they provide a service which focuses on what is important to the individual as well as the support they need.

Person Centred Thinking

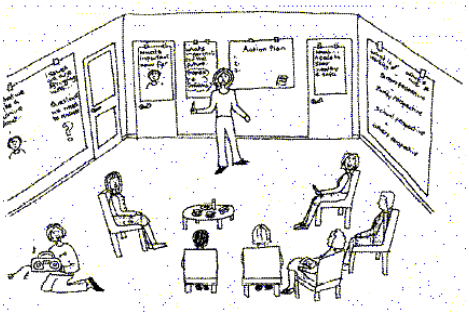


Person Centred Thinking is a way of working, there a number of tools which people who provide support can use to help them work in a more person centred way.

- How to sort what is important **to** a person from what is important **for** them
- How to address issues of health, safety and risk whilst supporting choice
- How to identify what the core responsibilities are for those who provide paid support
- How to consider what makes sense and what does not make sense about a person's life
- How to ensure effective support by matching characteristics of support staff to the person's needs

The Person Centred Thinking tools are fundamental to all other person centred approaches.

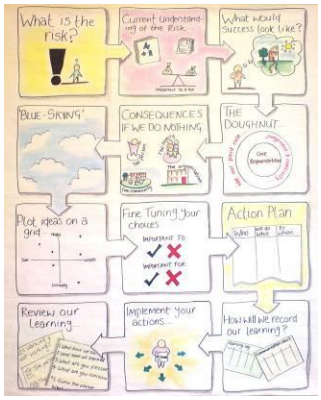
Person Centred Reviews



Person centred reviews are a way of facilitating reviews using person centred thinking tools, which has been developed by Helen Sanderson Associates. The person is involved throughout the whole process from start to finish **(it's their review),** family, friends and professionals support the person throughout.

Person centred reviews look at all aspects of the person's life and their relationships. A person centred review should be a positive experience that focuses on the person's strengths, talents and their gifts and develops an action plan that focuses on making things happen.

The information gathered from a review could be used to develop a one page plan.



Person Centred Risk Assessment

A twelve step process to manage risk in a more person centred way, developed by Helen Sanderson Associates.
The process helps professionals involved in assessing risk to address significant issues of health and safety whilst supporting choice by also taking into account things that are important to people.

Person Centred Teams

Person centred approaches are not only for people who use services, they can also be very useful tools for enabling teams to work together effectively. Person Centred Team Plans help teams to be clear about their purpose, to understand what is important to each member and what support they need to do a good job.

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ASPN

Adult Services Practice Notes

Dedicated to providing information on excellent family-centered practice with adults and their families.

Person-centered Thinking

When you get to work, what makes your day? How can you tell if it's going to be a good one or a bad one? Take just a moment to think about it and write some answers in the box at the bottom of this page. Are the things you wrote "big things" or "little" ones? For many people, finding the coffee already brewed or no crises in their voice mail are enough to get the day off to a good start, while no creamer or several panicky messages are enough to ratchet up the tension.

Now, choose one of the people you serve—maybe one with whom you're finding it somewhat difficult to work. What would that person say if you were to ask the same questions—what makes the difference between a good day and a bad day? You could try it, and you might be surprised at what you hear: "I got to have a bath and not a shower." "Mom let me help her get dressed without a fight." "The van arrived on time to pick me up." Often the difference between a good quality of life—whether in the workplace, at home, or in formal care—rests on seemingly small details of personal choice. The less ability or opportunity a person has to make and implement those choices, the more important it is for the people and institutions providing them with care or support to listen for and honor those choices to the extent possible.

Human services providers are often very good at identifying and arranging for services, but unless the services are provided in a way acceptable to the people using them, they may not work well—or at all. This can be a source of frustration for everyone concerned, as well as a poor use of time and money. Using the strategies of person-centered thinking makes it possible to get a more detailed view of needs and wishes—not just "6 hours a week of in-home aide services," but "half an hour each weekday morning at 8 to have a shower; hair washed every other day with citrus-scented shampoo" (and more detail should be added). Attention to values and preferences at this level may make all the difference in whether plans succeed or fail, whether from the

A Quick Taste of Person-centered Thinking

Make My Day!

I know it's going to be a good day when I arrive at work and:

I know it's going to be a bad day when I arrive at work and:

Here's what can make my good days better and my bad days less bad:

Adapted from *Person Centered Thinking*, a curriculum developed by The Learning Community for Person Centered Practices

> In a wide variety of settings people find themselves receiving acute or long term services and need to take positive control over what is happening with their life. Everyone seeks to have a balance in their lives between what is "important to" them and what is "important for" them (e.g., issues of health). When we find someone needs extensive care because of a disabling condition or serious illness, what is important for them often takes priority over what is important to them. Where the services are extensive and frequently intrusive, such as in nursing homes and other congregate living facilities, what is important to people can be lost.
>
> —The Learning Community for Person centered Practices, http://www.learningcommunity.us/about.html

Another Quick Taste of Person-centered Thinking

Important *To* You or *For* You?

Think about your worklife for a moment. What preferences and values do you have about your day-to-day activities: What is important *to* you? Then, consider what you need to do daily, both to succeed and to avoid bad consequences: What is important *for* you? Here are some possible examples. Cross out the ones that don't apply and add your own!

Important *To* Me	**Important *For* Me**
To watch the 11 p.m. news	To be at work on time by 7:30 a.m.
To have quiet time to drink my coffee and plan my day	To greet the seniors as soon as the center opens
To take as much time as I need working with each family	To assess new intake families as soon after contact as possible
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Can you think of other areas where what is important *to* you comes into conflict with what is important *for* you? Can you think of areas where what is important *to* you comes into conflict with what is important *to* or *for* your clients or your organization? In these cases, how is the conflict resolved? Compromise? Capitulation? Is there a better way?

Now, remember the person you were finding it hard to serve? What has that person said or otherwise made known about what's important *to* him or her? As a service provider, what have you identified as important *for* him or her? Where are the conflicts? How do you resolve them?

Adapted from *Person Centered Thinking*, a curriculum developed by The Learning Community for Person Centered Practices

point of view of the person or family receiving them or the provider trying to make them available.

Toward More Effective Services

North Carolina is making comprehensive changes to its long-term services and supports system, creating infrastructures to support individuals' independence, choice, dignity, and flexibility. The Office of Long Term Services and Supports (OLTS) is adapting and refining a curriculum based on person-centered principles and thinking. It has recently been presented to representatives of a wide variety of stakeholders in North Carolina and, based on their input, it will be tailored to fit the needs of case managers and direct care staff members across agencies that provide long-term services and supports—county DSSs, aging agencies, adult care homes and nursing facilities, Aging and Disability Resource Centers, and hospital discharge units, to name just a few. The curriculum provides a set of tools (you've had a brief glimpse of two of them) that can be used together or separately, as the situation requires, to make planning with people seeking services and their families more effective because the services are a closer fit with the values and preferences of the people receiving them.

This new curriculum has its roots in a person-centered model called *Essential Lifestyle Planning* (ELP) that is already being used by the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. This model was originally developed as a tool for helping people with severe disabilities reenter the community, often after years of institutional care. One of the early motivations for its development was the frequent lack of connection between care planning and plans-as-written and what actually happened to the people living with these plans. The goal of its developers, Michael Smull and Susan Burke-Harrison (joined now by many colleagues at The Learning Community for Person Centered Practices), was to help people with disabilities gain more control over their lives. Since its early years, ELP and the person-centered thinking that underpins it have been used with different groups of people in many other settings—

mental health institutions, nursing homes, and cancer care, to name just three.

One of the strengths of person-centered thinking is that once you understand its principles, it can be used to meet the needs of various population groups, including older and younger adults who need support in living with physical, sensory, or cognitive disabilities. Plans and services developed with people who need relatively little support will differ from plans and services for people who need support around the clock. Attention not just to needs identified by the provider (health, safety, etc.) but to the preferences and values of the person (challenge, pleasure, choice, etc.) improve the services and the quality of life of those using them.

Toward Person-centered Organizations

As you might guess from the two exercises you've tried, the strategies of person-centered thinking are transferable to work situations and can be used in contexts of different sizes: work units, organizations, and communities. Ultimately, OLTS's goal is to create and promote change in the culture of the system that provides support to people with disabilities through more person-centered day-to-day practices. In addition to sponsoring training, OLTS will solicit applications and select four organizations to participate in an intensive process in which person-centered thinking skills are integrated with management and quality improvement best practices. The organizations participating in these pilots will create leadership groups composed of workers, managers, and board members, families and individuals receiving services, and person-centered coaches, to improve the support of individuals, as well as refinement of the organizations' policies and practices.

Key Values and Principles of a Person-centered System

A person-centered system involves person-centered thinking, planning, and organizations. These guiding principles apply to the system serving all people who need long-term services and supports, and their families. A person-centered system acknowledges the role of families or guardians in planning for children/youth and for adults who need assistance in making informed choices.

To be person-centered means:

- Treating individuals and family members with dignity and respect
- Helping individuals and families become empowered to set and reach their personal goals
- Recognizing the right of individuals to make informed choices, and take responsibility for those choices and related risks
- Building on the strengths, gifts, talents, skills, and contributions of the individual and those who know and care about the individual
- Fostering community connections in which individuals can develop relationships, learn, work/produce income, actively participate in community life and achieve their full potential
- Promising to listen and to act on what the individual communicates
- Pledging to be honest when trying to balance what is important to and important for the person
- Seeking to understand individuals in the context of their age, gender, culture, ethnicity, belief system, social and income status, education, family, and any other factors that make them unique
- Acknowledging and valuing families and supporting their efforts to assist family members
- Recognizing and supporting mutually respectful partnerships among individuals, their families, communities, providers, and professionals
- Advocating for laws, rules, and procedures for providing services, treatment, and supports that meet an individual's needs and honor personal goals
- Endorsing responsible use of public resources to assure that qualified individuals are served fairly and according to need

Adopted by the DHHS Long Term Services and Supports Cabinet, January 10, 2008

> *I believe that these principles reflect consensus among representatives of individuals receiving and providing long term services and supports, and that they offer the Department a consistent framework within which all Divisions can work.*
>
> —Jackie Sheppard
>
> Assistant Secretary for Long Term Care and Family Services, to NC DHHS Division Directors and Long Term Services and Supports Cabinet, memo dated December 20, 2007

For more about the Office of Long Term Services and Supports in the NC Department of Health and Human Services, visit their website at http://www.ncdhhs.gov/olts/. For more about the two-day curriculum under development, go to http://www.learningcommunity.us/documents/PCTCurriculumDescriptionJuly2006.doc

To learn more about person-centered practices, visit the Learning Community's website at http://www.learningcommunity.us/home.html, which is the source of information about them. The two "Tastes of Person-centered Thinking" are adapted from their training event and used here with their permission.

Thanks to Ann Eller, Donna Holt, and Jan Moxley, of NC OLTS and Chris Egan, Coordinator, Developmental Disabilities Training Institute, School of Social Work, UNC-Chapel Hill, for help in preparing this issue. —mlm

How Does Person-centered Thinking Fit with What I Do Now?

Every human services worker who helps develop supports or programs for clients encounters the problem of plans that don't get done or that don't work, for any of a number of reasons. Person-centered thinking and planning provides tools that can add to the ones you probably use regularly, to help you get a much more focused picture of what clients and families need to thrive, regardless of their setting. Asking the two questions noted here—"good day/bad day" and "important *to/for* me" in the context of your usual assessment can get information about values that improve the chances that the plans you make together will work, as well as helping you identify what might not be working, especially when the *to* and the *for* of individuals and their support system don't match.

Extending and modifying the questions can help if you work with groups, too. Do the people who come to your senior center or adult day program like to start the day off with lots of talk and lots of activity, or do they need to ease into it? Do you have two groups—talkers and easers—and need to plan different ways people can start their day with you? When you listen closely to the individual preferences of the people you serveand how satisfied they are with your activities and programs, you can glean important clues about to how to make them more effective and better attended.

Since 1997, adult services workers in county departments of social services (and anyone else who has attended training through CARES) have been acquainted with the principles of family-centered work with adults and their families and with the administrative recommendations for agencies to support them. (See *Family Forum* 4(3) at http://ssw.unc.edu/cares/famforum/43frame.htm.) Person-centered thinking can provide additional tools for working with families. And, just as family-centered practice depends on organizations treating employees as they want adults and families to be treated, person-centered thinking can be powerful within a system of support: with individuals and families, with direct practice providers within their organization, and also among organizations in a community and state.

Whether you are the person seeking services, the service provider, or manager of a helping organization, Mick Jagger's observation, "You can't always get what you want," is still true. Person-centered thinking strategies don't guarantee that everyone gets everything they want all the time. Instead, the focus is on the struggle to create the best balance possible between what is important *to* individuals and what is important *for* their continued well-being. With closer attention to preferences, it may become much easier to help people get "what they need" more effectively.

Coming in the Fall Issue

CARES Training for Spring 2009 and opportunities to learn more about Person-centered Thinking.

Stay tuned!

ASPN: Adult Services Practice Notes

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The aspen is perhaps the world's largest organism. Although some aspen forests cover acres and seem to be composed of individuals in all stages of life, they share a common root system.

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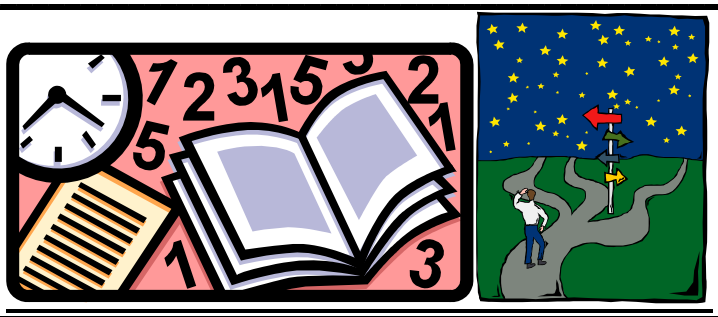

How Do We Describe People?

Person-Centered change challenges us to value each person as unique, filled with gifts and possibilities, to find ways to discover our common experience and work together to build a life where these gifts can be shared with others.

FROM SYSTEM-CENTERED	TOWARD PERSON-CENTERED
• Focus on labels	• See people first
• Emphasis on deficits, needs	• Search for capacities, gifts
• Invest in standardized testing and assessment	• Spend time getting to know people
• Depend on professionals to make judgments.	• Depend on people, families, and direct service workers to build good descriptions
• Generate written reports	• Gather folklore from people who know people well.
• See people in the context of human service systems.	• See people in the context of their local community.
• Distance people by emphasizing difference.	• Bring people together by discovering common experience.

Organizational Support

The facility is oriented and led in a manner that encourages staff to focus on person-centered care and workforce practices.

Components	Limited	Basic	Good	Fully Developed
1. Organizational commitment for person-centered care and workforce practices	. . . does not exist, or interest is low.	. . . is reflected in vision statements and business plans, but no resources are specifically earmarked to build a person-centered environment.	. . . is reflected in vision statements and organizational goals that are clear to staff. It is reflected in business plans, and senior leaders have allocated specific resources to build a person-centered environment.	. . . is clearly expressed in policies, procedures, hiring, training, supervision, and staff recognition practices. All staff members are accountable for building and maintaining a person-centered environment.
Points:	1 2 3	4 5 6	7 8 9	10 11 12
2. Senior leaders (administrator, DNS, RCMs. medical director, board members, etc.)	. . . have little understanding of the initiative, its purpose, and the activities required to achieve results; they are most concerned about costs.	. . . have a basic understanding of person-centered care and workforce practices and are interested in learning more. They have begun to look at costs and benefits, and look for resources.	. . . have a more specific understanding of person-centered care and workforce practices, especially in selected cases. They are committed to learning more, and have dedicated some resources (e.g., budget, designated team, and assigned leader).	. . . fully understand and embrace the initiative and dedicate significant budget and personnel resources to it (e.g., training for all levels of staff in person-centered care practices). They are committed to empowering the staff to help build a person-centered environment.
Points:	1 2 3	4 5 6	7 8 9	10 11 12
3. Staff at all levels	. . ..have little understanding of the initiative, its purpose, and the activities required to achieve results. They are skeptical about its potential and concerned about impact on work.	. . . have a basic understanding of person-centered care and workforce practices and are interested in learning more. They rarely perceive themselves as responsible for shaping or implementing the initiative.	. . . have more specific understanding of person-centered care and workforce practices and are committed to implementation in selected areas of practice. Some staff at all levels participate in planning and implementation.	. . . fully understand and are committed to the initiative and to transforming care. All staff feel responsible for making the care environment person-centered. Staff members fully understand their roles, which include active participation in planning, implementation, and evaluation.
Points:	1 2 3	4 5 6	7 8 9	10 11 12

Organizational Support

4. A leadership team for person-centered care and workforce practices	. . . does not exist.			. . . has been identified or appointed, but does not represent all disciplines or levels of staff. Team goals are not clear and meetings do not happen consistently. The team is mostly led by senior leadership (e.g., DNS, RCM, charge nurse, administrator). Staff nurses, DCWs, and others rarely speak in meetings.			. . . is in place, with some representation from all levels and disciplines. Goals are clear, and meetings are regular (though are often cancelled). Staff nurses, DCWs, and others frequently express opinions, help make decisions, and assume leadership roles.			. . . is in place, with broad representation from all levels and disciplines. The team involves other staff to set clear goals. The team meets regularly. Staff nurses, DCWs, and others frequently assume leadership roles, with full support from senior leaders. All team members are fully engaged and active participants. Team decisions are recorded and shared.		
Points:	1	2	3	4	5	6	7	8	9	10	11	12

Total Organizational Support points: _____ **Average Score (Organizational Support points / 4) _____**

Resident Focus

Systems are created and supported within which individual preferences are honored and defended.

Components	Limited	Basic	Good	Fully Developed
5. Best practices for person-centered care (PCC)	Staff have little knowledge about PCC or which practices contribute to PCC. The organization allocates few or no resources for identifying best practices.	Staff education includes basic information about PCC. The work environment emphasizes respect for residents, but staff are not assisted in examining how to apply PCC.	Education and work environment emphasize multiple dimensions of PCC. Many staff, including DCWs, are familiar with best practices in addressing some dimensions (e.g., dining, bathing, pain, dementia care). Resident preferences and choices are supported when possible.	Staff are encouraged to innovate or adapt ideas for PCC; residents and families are fully involved. Effective feedback loops are in place for continuous improvement. Staff serve as mentors to other long-term care facilities.
Points:	1 2 3	4 5 6	7 8 9	10 11 12
6. The resident's preferences or choices about meal times, bathing, etc.	. . . are rarely recorded in the Care Plan; the nursing staff directs or schedules most care routines.	. . . are considered in some matters (e.g., what to wear, which toiletries to use, where to spend time), but most care routines and schedules are determined by DCWs under the direction of nursing staff. Preferences and choices are not consistently included in the Care Plan.	. . . are emphasized in most aspects of daily living (e.g., choices of food, morning and night routines, bathing, activities, socializing). Direct care workers' roles include working out routines to support resident choice. Individual choices are central to Care Plans.	. . . come first. Residents determine their own schedules, meals, activities, and caregivers, as well as whom they room with. Residents are encouraged to set their own goals. The preferences are the basis of the Care Plan, which is easily accessible and updated regularly.
Points:	1 2 3	4 5 6	7 8 9	10 11 12
7. Consistent assignments of staff to residents	. . . are not in place; staff rotate regularly throughout the facility.	. . . are made for some staff and residents. There is recognition that consistent assignments are beneficial for residents.	. . . are almost always in place except when staffing issues preclude them. Leadership emphasizes and supports DCWs in nurturing their relationships with residents.	. . . are determined by the quality of resident–staff relationships; honoring these relationships is the basis for staffing decisions. Policies and procedures address staffing issues to protect consistent assignments (e.g., float and on-call staff positions are available and are filled by staff who prefer to rotate).
Points:	1 2 3	4 5 6	7 8 9	10 11 12

Resident Focus

8. The opinions of residents and/or their families	. . . are rarely solicited except at time of admission.	. . . are shared with administration and nursing leadership as families bring them up; the facility has no formal mechanisms to solicit opinions.	. . . are solicited through resident councils and family councils, support groups, and surveys. Attendance is uneven and not all participate. Survey data may not be routinely analyzed.	. . . are actively solicited. Resident and family councils are active and well supported. The facility routinely measures resident and family satisfaction (for example, through surveys or focus groups). Residents' and families' opinions are valued, shared with staff, and used in care planning and program development.
Points:	1 2 3	4 5 6	7 8 9	10 11 12
9. Community connections	. . . are not part of the programming. "Community" is seen as something outside the facility, and residents are connected to the community only through family members.	. . . outside of the facility are being considered, but have not yet been implemented. Internal activity programs emphasize socializing with others within structured activities as a way to build relationships.	. . . outside the facility include volunteer activities with some community organizations. Internal activity programs include occasional outings for some residents. Activities emphasize building and nurturing relationships beyond formal activity programs.	. . . outside the facility are actively sought, especially in areas that enrich residents' quality of life; multiple organizations are part of resident, family, and staff life. Most residents leave the facility regularly for pleasurable activities. A sense of community exists among residents, family, and staff; residents feel they are contributing members of the community.
Points:	1 2 3	4 5 6	7 8 9	10 11 12
10. Knowing the resident as a person	. . . is not emphasized beyond information collected for MDS and other required reporting. Information asked relates only to care needs.	. . . is emphasized when a resident moves in and includes learning personal information about family, work history, hobbies. Information is not consistently shared with staff.	. . . is a continuous process, with staff, including DCWs, increasing their knowledge of resident biography (e.g., what and who is or was important to the resident, the resident's cultural and spiritual beliefs). Efforts are made to share information with all staff.	. . . is paramount. Staff understand the resident's history and current wishes and provide care in keeping with that knowledge. Staff help residents achieve personal goals that may be unrelated to care needs, emphasizing residents' strengths over disabilities.
Points:	1 2 3	4 5 6	7 8 9	10 11 12

Total Resident Focus points: _____ **Average Score (Resident Focus points / 6): _____**

Workforce Practices

Best practices are in effect to ensure a qualified, competent, and satisfied workforce.

	Components	Limited	Basic	Good	Fully Developed
11.	**Recruitment practices** (e.g., advertising, interviewing, selection)	. . . are outdated, or do not get the desired results. Few resources are allocated to recruitment	. . . emphasize filling positions as quickly as possible rather than finding best match for position.; recruitment overshadows retention practices. However, recruitment and selection of staff are based on specific criteria. Job interviews are conducted systematically and new staff are provided with accurate job descriptions.	. . . are considered and planned in tandem with retention. Interview process is consistent and systematic across departments. Staff are involved in hiring peers and have a stake in their success.	. . . use a targeted approach for recruiting ideal candidates (e.g., frontline staff involvement; competency-based position descriptions that reflect mission and goals and provide a job preview; rigorous intake and assessment). Residents are involved in hiring and evaluating staff.
	Points:	1 2 3	4 5 6	7 8 9	10 11 12
12.	**Retention practices** (systems for orienting, training, mentoring staff)	. . . are not in place.	. . . are left to the discretion of department managers and supervisory staff. An orientation program emphasizing PCC & best workforce development practices is being considered but is not in place, or is offered inconsistently. New workers are assigned to experienced staff when staffing allows. Inservices provide training on topics required by regulation.	. . . include specially trained and compensated staff who are designated as mentors and are available for initial orientation. Consistent information is shared during orientation, training, and mentoring. Inservices go beyond topics required by regulation, including information on culture change and PCC. Funding is available for continuing education for some staff.	. . . include designated skilled and compensated mentors, with systems in place to protect their time with newly hired staff. All staff are responsible for supporting new staff. Orientation, training, and mentoring all reflect the organization's mission and goals
	Points:	1 2 3	4 5 6	7 8 9	10 11 12
13.	**Best practices for workforce development**	Senior leaders have little knowledge about what practices contribute to workforce development. Few resources are allocated to investment in staff. Senior leadership makes most decisions about staff roles and responsibilities.	Senior leaders have basic understanding of workplace practices that promote staff satisfaction. Senior leadership makes most decisions about workforce practices without staff input.	Peer mentoring programs are under development or in early stages of implementation. Significant resources are dedicated to empowering staff. Senior leadership actively seeks opinions of other staff before making decisions.	Staff, including DCWs, are empowered to make decisions about their own work and how they will carry out resident-directed care plans. Supervisors are trained in facilitating teams and empowering staff. Decision making is decentralized, with administration playing a facilitative role. DCWs and other staff have a voice and major role in designing and implementing change.
	Points:	1 2 3	4 5 6	7 8 9	10 11 12

Workforce Practices

14.	**Becoming a learning community**	. . . is not a priority for senior leaders, and few resources are invested in staff development Senior leadership makes most decisions about day-to-day operations.			. . . is acknowledged as a legitimate investment, but resources continue to focus on staffing issues rather than development. Inservice education is limited to topics required by regulation; not a priority for most staff.			. . . is recognized and supported. Staff are encouraged to try new things, and it feels "safe" to make mistakes. Educational resources are available to senior staff and managers (e.g., opportunities & funding to attend classes or CE offerings, journal subscriptions, books, access to Internet resources, outside consultants).			. . . is seen as a strategic approach, and consistently reinforced by senior leadership. Continuous learning is a priority for all staff. The facility offers a rich variety of training in response to staff-identified topics. Continuing education outside of the facility is available to all staff and used by most.		
	Points:	1	2	3	4	5	6	7	8	9	10	11	12
15.	**Supervisory staff**	. . . have little or no experience and training to be supervisors. Some may not perceive supervision within their work roles.			. . . can perform basic supervisory tasks such as scheduling and performance evaluations, and providing direction using a "top down" approach.			. . . have good supervisory skills with respect to communication, providing clear expectations, and promoting teamwork. They seek staff input on scheduling, performance evaluation, and decision making,			. . . use a supportive, problem-solving approach to supervision (e.g., coaching) that empowers and supports staff in making decisions about their work. They delegate substantial authority to staff, such as scheduling, making hiring decisions.		
	Points:	1	2	3	4	5	6	7	8	9	10	11	12
16.	**Supportive services for DCWs** (e.g., access to short-term loans, educational reimbursement, child care, counseling for domestic violence)	. . . are not in place.			. . . are ad hoc, inconsistent, and not well organized or supported.			. . . are supported in some areas and available on request.			. . . are broad in scope, well organized, publicized to all staff, and easy to access.		
	Points:	1	2	3	4	5	6	7	8	9	10	11	12

Total Workforce Practices points: _____ Average Score (Workforce Practices points / 6) _____

Care Planning

The care planning process supports excellent care that meets resident needs and preferences and helps them achieve personal goals.

	Components	Limited	Basic	Good	Fully Developed
17.	**The care planning process**	. . . is chiefly in the hands of the Resident Care Manager(s).	. . . includes some consultation with DCWs and family members for some residents.	. . . includes systems to receive and use information from DCWs, residents, and families if they choose to provide it. Mechanisms to ensure and support full participation are limited.	. . . involves a multidisciplinary or integrated care team. DCWs have an equal voice, and residents and family members have opportunities for full participation
	Points:	1 2 3	4 5 6	7 8 9	10 11 12
18.	**Integration* of clinical best practices for selected Quality Measures**	. . . has not occurred. The facility does not use evidence-based practice guidelines, or it applies outdated guidelines.	. . . is occurring in some areas, like screening or assessment. Checklists and other guidelines are available for some Quality Measures, but their use is left to the discretion of supervisors.	. . . is occurring in the care planning process. The Care Plan addresses key clinical Quality Measures; clinical best practices guidelines related to these and other quality measures are used routinely.	. . . addresses potential conflicts between best practices and resident preferences and values; the multidisciplinary team considers and resolves any issues.
	Points:	1 2 3	4 5 6	7 8 9	10 11 12
19.	**The Care Plan document**	. . . is a standardized, generic plan focusing mainly on problems or limitations, with little content that distinguishes between residents.	. . . includes some information about resident preferences and biography.	. . . includes multiple dimensions related to PCC as well as strengths and goals of residents.	. . . includes all or most domains related to PCC; plans clearly reflect the resident so that new staff reading the Care Plan can provide competent care and address most of the resident's needs and preferences.
	Points:	1 2 3	4 5 6	7 8 9	10 11 12
20.	**The Care Plan**	. . . is not accessible to DCWs and some staff nurses.	. . . is available in sections, but DCWs and some nurses are not encouraged to use it, or have limited time to review it.	. . . is available and accessible. Most care staff review them periodically and indicate when the plan should be changed.	. . . is considered a living document. It is routinely used by all DCWs, nurses, and other care staff to guide their work and to communicate changes in resident needs or concerns.
	Points:	1 2 3	4 5 6	7 8 9	10 11 12

Total Care Planning points: _____ Average Score (Care Planning. points / 4) _____

* Integration refers to incorporation in screening, assessment, Care Plans, and monitoring

Quality Assurance/Quality Improvement

Improving care for residents is an ongoing process that expands beyond regulatory requirements.

	Components	Limited			Basic			Good			Fully Developed		
21.	**Internal efforts to improve systems of care for residents**	. . . are ad hoc and not well organized or supported.			. . . use ad hoc approaches for targeted problems as they emerge.			. . . are based on "best practices" or proven strategies for targeted problems.			. . . use a proven improvement strategy to proactively meet organizational goals.		
	Points:	1	2	3	4	5	6	7	8	9	10	11	12
22.	**Performance measures to evaluate success**	. . . are seldom set.			. . . are based on absence of deficiencies or citations from regulatory agencies.			. . . use both a baseline and a target measure for success.			. . . are used to continually evaluate progress, celebrate successes, and identify new opportunities for improvement.		
	Points:	1	2	3	4	5	6	7	8	9	10	11	12
23.	**System improvements**	. . . rarely move out of the idea or discussion stage.			. . . have been implemented only when a staff member has been passionate about seeing them through.			. . . have been implemented but not sustained over time.			. . . are implemented using a phased rollout strategy that builds support throughout the organization.		
	Points:	1	2	3	4	5	6	7	8	9	10	11	12

Total QA/QI points: _____ **Average Score (QA/QI points / 3) _____**

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The contents presented do not necessarily reflect CMS policy.
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Graphing Your Milestones

Enter your Average Scores from the end of each Path, then color in the boxes for each Path to create a graph of your milestones (round decimal fractions upward).

Organizational Support	Resident Focus	Workforce Practices	Care Planning	Quality Assurance/ Quality Improvement
12	12	12	12	12
11	11	11	11	11
10	10	10	10	10
9	9	9	9	9
8	8	8	8	8
7	7	7	7	7
6	6	6	6	6
5	5	5	5	5
4	4	4	4	4
3	3	3	3	3
2	2	2	2	2
1	1	1	1	1
Score: _____	**Score: _____**	**Score: _____**	**Score: _____**	**Score: _____**




RESTRAINT AND SECLUSION: RESOURCE DOCUMENT

U.S. Department of Education





This document was produced under U.S. Department of Education Contract No. ED-OSE-09-O-0058 with the American Institutes for Research. Renee Bradley served as the contracting officer's representative. This resource document contains websites and resources created by a variety of organizations. These websites and resources are provided for the user's convenience. No official endorsement by the U.S. Department of Education of any product, commodity, service or enterprise mentioned in this report or on websites referred to in this report is intended or should be inferred. The views expressed herein do not necessarily represent the positions or policies of the Department of Education and no official endorsement of them by the Department is intended or should be inferred.

U.S. Department of Education
Arne Duncan
Secretary

May, 2012

This resource is available on the Department's Web site at: www.ed.gov/policy/restraintseclusion

On request, this publication is available in alternate formats, such as Braille, large print or compact disc.
For more information, contact the Department's Alternate Format Center at 202-260-0852 or 202-260-0818.

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THE SECRETARY OF EDUCATION
WASHINGTON, DC 20202

May 15, 2012

As education leaders, our first responsibility must be to ensure that schools foster learning in a safe and healthy environment for all our children, teachers, and staff. To support schools in fulfilling that responsibility, the U.S. Department of Education has developed this document that describes 15 principles for States, school districts, schools, parents, and other stakeholders to consider when developing or revising policies and procedures on the use of restraint and seclusion. These principles stress that every effort should be made to prevent the need for the use of restraint and seclusion and that any behavioral intervention must be consistent with the child's rights to be treated with dignity and to be free from abuse. The principles make clear that restraint or seclusion should never be used except in situations where a child's behavior poses imminent danger of serious physical harm to self or others, and restraint and seclusion should be avoided to the greatest extent possible without endangering the safety of students and staff. The goal in presenting these principles is to help ensure that all schools and learning environments are safe for all children and adults.

As many reports have documented, the use of restraint and seclusion can have very serious consequences, including, most tragically, death. Furthermore, there continues to be no evidence that using restraint or seclusion is effective in reducing the occurrence of the problem behaviors that frequently precipitate the use of such techniques. Schools must do everything possible to ensure all children can learn, develop, and participate in instructional programs that promote high levels of academic achievement. To accomplish this, schools must make every effort to structure safe environments and provide a behavioral framework, such as the use of positive behavior interventions and supports, that applies to all children, all staff, and all places in the school so that restraint and seclusion techniques are unnecessary.

I hope you find this document helpful in your efforts to provide a world-class education to America's children. Thank you for all you do to support our schools, families, and communities and for your work on behalf of our nation's children.

Arne Duncan

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Restraint and Seclusion: Resource Document[1]


School should be a safe and healthy environment in which America's children can learn, develop, and participate in instructional programs that promote high levels of academic achievement.

The foundation of any discussion about the use of restraint and seclusion is that every effort should be made to structure environments and provide supports so that restraint and seclusion are unnecessary. As many reports have documented, the use of restraint and seclusion can, in some cases, have very serious consequences, including, most tragically, death. There is no evidence that using restraint or seclusion is effective in reducing the occurrence of the problem behaviors that frequently precipitate the use of such techniques.

Physical restraint or seclusion should not be used except in situations where the child's behavior poses imminent danger of serious physical harm to self or others and restraint and seclusion should be avoided to the greatest extent possible without endangering the safety of students and staff. Schools should never use mechanical restraints to restrict a child's

freedom of movement.[2] In addition, schools should never use a drug or medication to control behavior or restrict freedom of movement unless it is (1) prescribed by a licensed physician, or other qualified health professional acting under the scope of the professional's authority under State law; and (2) administered as prescribed by the licensed physician or other qualified health professional acting under the scope of the professional's authority under State law. Teachers, administrators, and staff understand that students' social behavior can affect their academic learning. In many high-performing schools effective academic instruction is combined with effective behavior supports to maximize academic engagement and, thus, student achievement. Students are more likely to achieve when they are (1) directly taught school and classroom routines and social expectations that are predictable and contextually relevant; (2) acknowledged clearly and consistently for their displays of positive academic and social behavior; and (3) treated by

1 The U.S. Department of Education issues this Resource Document to provide guidance, and describe fifteen principles that States, school districts, school staff, parents, and other stakeholders may find helpful to consider when States, localities, and districts develop practices, policies, and procedures on the use of restraint and seclusion in schools. Our goal in providing this information is to inform States and school districts about how they can help to ensure that schools are safe learning environments for all students. As guidance, the extent to which States and school districts implement these principles in furtherance of that goal is a matter for State and local school officials to decide using their professional judgment, especially in applying this information to specific situations and circumstances. This document does not set forth any new requirements, does not create or confer any rights for or on any person or require specific actions by any State, locality, or school district.

We are interested in making this document as informative and useful as possible. If you are interested in commenting on this document, please e-mail your comments to Restraint.Seclusion@ed.gov or write to us at the following address: US Department of Education, 550 12th Street SW, PCP Room 4160, Washington, DC 20202-2600.

2 As the definition on page six of this document makes clear, "mechanical restraint" as used in this document does not include devices implemented by trained school personnel, or utilized by a student that have been prescribed by an appropriate medical or related services professional and are used for the specific and approved purposes for which such devices were designed.

others with respect. (Algozzine, R., Wang, C., and Violette, C., 2011; McIntosh, K., Chard, D., Boland, J., and Horner, R., 2006). Building effective behavioral supports in schools also involves several ongoing interrelated activities, including (1) investing in the whole school rather than just students with problem behavior; (2) focusing on preventing the development and occurrence of problem behavior; (3) reviewing behavioral data regularly to adapt school procedures to the needs of all students and their families; and (4) providing additional academic and social behavioral supports for students who are not making expected progress (Sugai, G., Horner, R., Algozzine, R., Barrett, S., Lewis, T., Anderson, C., Bradley, R., Choi, J. H., Dunlap, G., Eber, L., George, H., Kincaid, D., McCart, A., Nelson, M., Newcomer, L., Putnam, R., Riffel, L., Rovins, M., Sailor, W., Simonsen, B. (2010)).

Positive behavior interventions and supports (PBIS) is a multi-tiered school-wide approach to establishing the social culture that is helpful for schools to achieve social and academic gains while minimizing problem behavior for all children. Over 17,000 schools across the country are implementing PBIS, which provides a framework for decision-making that guides the implementation of evidence-based academic and behavioral practices throughout the entire school, frequently resulting in significant reductions in the behaviors that lead to office disciplinary referrals, suspensions, and expulsions. While the successful implementation of PBIS typically results in improved social and academic outcomes, it will not eliminate all behavior incidents in a school (Bradshaw, C., Mitchell, M., and Leaf, P. (2010); Muscott, H., and Mann, E. (in press); Lassen, S., Steele, M., and Sailor, W. (2006)). However, PBIS is an important preventive framework that can increase the capacity of school staff to support all children, including children with the most complex behavioral needs, thus reducing the instances that require intensive interventions.

Restraint or seclusion should not be used as routine school safety measures; that is, they should not be implemented except in situations where a child's behavior poses imminent danger of serious physical harm to self or others and not as a routine strategy implemented to address instructional problems or inappropriate behavior (e.g., disrespect, noncompliance, insubordination, out of seat), as a means of coercion or retaliation, or as a convenience.



Background



On July 31, 2009, Secretary of Education Arne Duncan sent a letter to Chief State School Officers stating that he was deeply troubled about the current use and effects of restraint and seclusion, which were the subject of testimony before the Education and Labor Committee in the U.S. House of Representatives' hearing examining the abusive and potentially deadly application of restraint and seclusion techniques in schools.

In his letter, Secretary Duncan encouraged each State to review its current policies and guidelines on the use of restraint and seclusion in schools to help ensure that every student is safe and protected, and, if appropriate, to develop or revise its policies and guidelines. In addition, Secretary Duncan urged the Chiefs to publicize these policies and guidelines so that administrators, teachers, and parents understand and consent to the limited circumstances under which these techniques may be used; ensure that parents are notified when these interventions occur; provide the resources needed to successfully implement the policies; and hold school districts accountable for adhering to the guidelines. The letter went on to highlight the use of PBIS as an important preventive approach that can increase the capacity of the school staff to support children with the most complex behavioral needs, thus reducing the instances that require intensive interventions.

Subsequently, the U.S. Department of Education (the Department) asked its regional Comprehensive Centers to collect each State's statutes, regulations, policies, and guidelines regarding the use of restraint and seclusion, and posted that information on the Department's Web site.[3] Additionally, the Department's Office for Civil Rights revised the *Civil Rights Data Collection* beginning with school year 2009-2010 to require reporting of the total number of students subjected to restraint or seclusion disaggregated by race/ethnicity, sex, limited English proficiency status, and disability, and to collect the total number of times that restraint or seclusion occurred.[4]

Additionally, in 2009, the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services (DHHS), asked the Department's Office of Special Education Programs (OSEP) to review a paper commissioned by SAMHSA (with the assistance of an expert work group) addressing the issue of restraint and seclusion in schools. Based on Secretary Duncan's letter to the Chief State School Officers and the experiences of SAMHSA with reducing, and in some cases eliminating, the use of restraint and seclusion in mental health facilities, the Department determined that it would be beneficial to all children if information and technical assistance were provided to State departments of education, local school districts, and preschool, elementary, and secondary schools regarding limiting the use of restraint and seclusion to situations involving imminent danger of serious physical harm to children or others.[5]

3 A revised version of that information is included in this document as Attachment A.

4 These data are available at http://ocrdata.ed.gov.

5 More detail about these efforts is included later in this document.

The purpose of this Resource Document is to present and describe 15 principles for State, district, and school staff; parents; and other stakeholders to consider when States, localities, and districts develop policies and procedures, which should be in writing on the use of restraint and seclusion. The principles are based on the nine principles that Secretary of Education Arne Duncan articulated in a 2009 letter to Chairman Christopher Dodd, Chairman George Miller, and Representative Cathy McMorris Rodgers in response to proposed legislation on restraint and seclusion. In his letter, the Secretary affirmed the Department's position that restraint and seclusion should not be used except when necessary to protect a child or others from imminent danger of serious physical harm. Since the Secretary issued his 2009 letter, the Department, working with the Department of Health and Human Services, further developed and refined the principles. The Department and the Department of Health and Human Services urge States, local districts, and schools to adopt policies that consider these 15 principles as the framework for the development and implementation of policies and procedures related to restraint and seclusion to help ensure that any use of restraint or seclusion in schools does not occur, except when there is a threat of imminent danger of serious physical harm to the student or others, and occurs in a manner that protects the safety of all children and adults at a school. The goal in presenting these principles is to help ensure that all schools and all learning environments are safe for all children and adults. This Resource Document discusses the context within which these principles were developed, lists the principles, and highlights the current state of practice and implementation considerations for each principle. Additionally, this document provides a synopsis of ongoing efforts by Federal agencies to address national concerns about using restraint and seclusion in schools. Two attachments at the end of this document provide information about State policies on the use of restraint and seclusion in our nation's public schools and an annotated resource guide on the use of restraint and seclusion in schools.

> In cases where a student has a history of dangerous behavior for which restraint or seclusion was considered or used, a school should have a plan for: (1) teaching and supporting more appropriate behavior; and (2) determining positive methods to prevent behavioral escalations that have previously resulted in the use of restraint or seclusion.

OTHER SIGNIFICANT FEDERAL ACTIVITY REGARDING THE USE OF RESTRAINT AND SECLUSION IN SCHOOLS

U.S. Government Accountability Office Report

The U.S. House of Representatives' Committee on Education and Labor requested the U.S. Government Accountability Office (GAO) to review the available evidence on the use of restraint and seclusion

that resulted in death and abuse at public and private schools and treatment centers. The GAO reviewed applicable Federal and State laws, interviewed knowledgeable State officials and recognized experts, and examined available evidence of abuse allegations from parents, advocacy organizations, and the media for the period between 1990 and 2009. These evidence reviews also involved the examination of selected closed cases, including police and autopsy reports and school policies on restraint or seclusion related to these cases.

The GAO report, titled *Examining the Abusive and Deadly Use of Seclusion and Restraint in Schools* (issued May 19, 2009), included three sets of findings. First, the GAO found that there were no current Federal regulations, but a wide variety of divergent State regulations, governing the use of restraint and seclusion in public and private schools. Second, the GAO reported that there were no reliable national data on when and how often restraint and seclusion are being used in schools, or on the extent of abuse resulting from the use of these practices in educational settings nationally. However, the GAO identified several hundred cases of alleged abuse, including deaths that were related to the use of restraint or seclusion of children in public and private schools. Finally, the GAO provided detailed documentation of the abuse of restraint or seclusion in a sample of 10 closed cases that resulted in criminal convictions, findings of civil or administrative liability, or a large financial settlement. The GAO further observed that problems with untrained or poorly trained staff were often related to many instances of alleged abuse.

Congressional Hearings and Proposed Legislation

The GAO report was presented to the U.S. House of Representatives' Committee on Education and Labor at a hearing on restraint and seclusion on May 19, 2009. Testimony at this and other hearings, together with related work by the Committee, led to the drafting of proposed Federal legislation on the use of restraint and seclusion in schools.

The 111th Congress considered legislation on the use of restraint and seclusion in schools. The House bill (H.R. 4247) was titled *Keeping All Students Safe Act*, and two Senate bills were introduced, *Preventing Harmful Restraint and Seclusion in Schools Act (S. 2860)* and *Keeping All Students Safe Act (S. 3895)*. In April, 2011, H.R. 4247 was reintroduced in the 112th Congress as H.R. 1381. And in December, 2011, S. 2020, *Keeping All Students Safe Act*, was introduced in the 112th Congress. The shared purposes of these bills were to (1) limit the use of restraint and seclusion in schools to cases where there

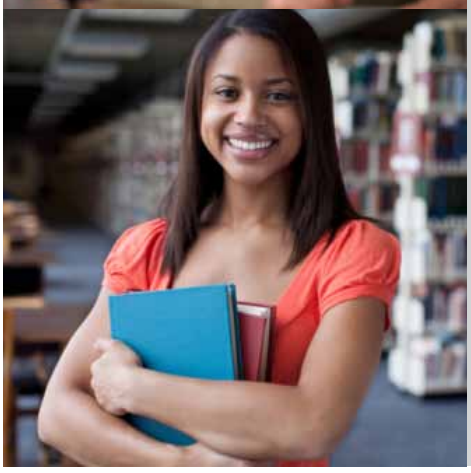
First, the GAO found that there were no current Federal regulations, but a wide variety of divergent State regulations, governing the use of restraint and seclusion in public and private schools.

is imminent danger of physical injury to the student or others at school; (2) provide criteria and steps for the proper use of restraint or seclusion; and (3) promote the use of positive reinforcement and other, less restrictive behavioral interventions in school. These measures also would have authorized support to States and localities in adopting more stringent oversight of the use of restraint and seclusion in schools, and would have established requirements for collecting data on the use of these practices in schools. Both the House and Senate bills were introduced and debated by their respective chambers in the 111th Congress, but only the House bill had passed when the Congressional session ended in December 2010. Therefore, no legislation related to restraint and seclusion in schools was enacted by the 111th Congress, nor has action on such legislation been taken, to date, in the 112th Congress.

Congressional Research Service Report

In October, 2010, the Congressional Research Service issued a report to Congress titled ***The Use of Seclusion and Restraint in Public Schools: The Legal Issues***. The report focused on the legal issues regarding the use of seclusion and restraint in schools, including their use with children covered by the Individuals with Disabilities Education Act (IDEA) and with children not covered by IDEA. The report addressed (1) definitions (*Civil Rights Data Collection* definitions); (2) constitutional issues; (3) IDEA judicial decisions related to seclusion and restraint; (4) State laws and policies; and (5) Federal legislation.

Terms Used In This Document



The Department's Office for Civil Rights (OCR) began collecting data on the use of restraint and seclusion in schools as part of the Department's 2009-2010 *Civil Rights Data Collection* (CRDC) and defined key terms related to restraint and seclusion.

References in this document to "restraint" encompass the terms "physical restraint" and "mechanical restraint" as defined in the CRDC. References to "seclusion" encompass "seclusion" as defined in the CRDC. According to the GAO report, each of these types of restraint is currently being used in schools.

The CRDC defines *physical restraint* as:

- A personal restriction that immobilizes or reduces the ability of a student to move his or her torso, arms, legs, or head freely. The term physical restraint does not include a physical escort. Physical escort means a temporary touching or holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing a student who is acting out to walk to a safe location.

The CRDC defines *mechanical restraint* as:

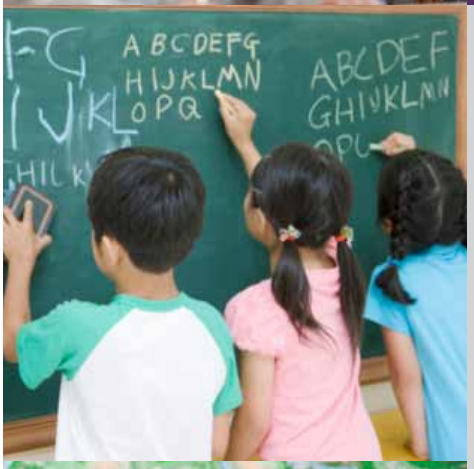
- The use of any device or equipment to restrict a student's freedom of movement. This term does not include devices implemented by trained school personnel, or utilized by a student that have been prescribed by an appropriate medical or related services professional and are used for the specific and approved purposes for which such devices were designed, such as:
  - Adaptive devices or mechanical supports used to achieve proper body position, balance, or alignment to allow greater freedom of mobility than would be possible without the use of such devices or mechanical supports;
  - Vehicle safety restraints when used as intended during the transport of a student in a moving vehicle;
  - Restraints for medical immobilization; or
  - Orthopedically prescribed devices that permit a student to participate in activities without risk of harm.

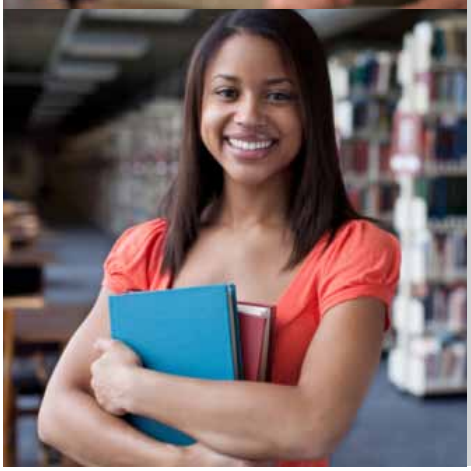
The CRDC defines *seclusion* as:

- The involuntary confinement of a student alone in a room or area from which the student is physically prevented from leaving. It does not include a timeout, which is a behavior management technique that is part of an approved program, involves the monitored separation of the student in a non-locked setting, and is implemented for the purpose of calming.

A copy of the 2009-2010 CRDC and the OCR definitions of restraint and seclusion can be found at the following Web site: http://www2.ed.gov/about/offices/list/ocr/whatsnew.html. Restraint and seclusion data are available at http://ocrdata.ed.gov.[6]

6 As these terms are used in this document, "restraint" does not include behavioral interventions used as a response to calm and comfort (e.g., proximity control, verbal soothing) an upset student and "seclusion" does not include classroom timeouts, supervised in-school detentions, or out-of-school suspensions.





Fifteen Principles[7]

The Department, in collaboration with SAMHSA, has identified 15 principles that we believe States, local school districts, preschool, elementary, and secondary schools, parents, and other stakeholders should consider as the framework for when States, localities, and districts develop and implement policies and procedures, which should be in writing related to restraint and seclusion to ensure that any use of restraint or seclusion in schools does not occur, except when there is a threat of imminent danger of serious physical harm to the student or others, and occurs in a manner that protects the safety of all children and adults at school.

The Department recognizes that States, localities, and districts may choose to exceed the framework set by the 15 principles by providing additional protections from restraint and seclusion.

FIFTEEN PRINCIPLES

1. Every effort should be made to prevent the need for the use of restraint and for the use of seclusion.
2. Schools should never use mechanical restraints to restrict a child's freedom of movement, and schools should never use a drug or medication to control behavior or restrict freedom of movement (except as authorized by a licensed physician or other qualified health professional).
3. Physical restraint or seclusion should not be used except in situations where the child's behavior poses imminent danger of serious physical harm to self or others and other interventions are ineffective and should be discontinued as soon as imminent danger of serious physical harm to self or others has dissipated.
4. Policies restricting the use of restraint and seclusion should apply to all children, not just children with disabilities.
5. Any behavioral intervention must be consistent with the child's rights to be treated with dignity and to be free from abuse.

Every effort should be made to prevent the need for the use of restraint and for the use of seclusion.

6. Restraint or seclusion should never be used as punishment or discipline (e.g., placing in seclusion for out-of-seat behavior), as a means of coercion or retaliation, or as a convenience.
7. Restraint or seclusion should never be used in a manner that restricts a child's breathing or harms the child.
8. The use of restraint or seclusion, particularly when there is repeated use for an individual child, multiple uses within the same classroom, or multiple uses by the same individual, should trigger a review and, if appropriate, revision of strategies currently in place to address dangerous behavior;[8] if positive behavioral strategies are not in place, staff should consider developing them.
9. Behavioral strategies to address dangerous behavior that results in the use of restraint or seclusion should address the underlying cause or purpose of the dangerous behavior.
10. Teachers and other personnel should be trained regularly on the appropriate use of effective alternatives to physical restraint and seclusion, such as positive behavioral interventions and supports and, only for cases involving imminent danger of serious physical harm, on the safe use of physical restraint and seclusion.

7 This Resource Document addresses the restraint or seclusion of any student regardless of whether the student has a disability. Federal laws, including the IDEA, the Americans with Disabilities Act of 1990, as amended, and Section 504 of the Rehabilitation Act of 1973, as amended, must be followed in any instance in which a student with a disability is restrained or secluded, or where such action is contemplated. This Resource Document does not, however, address the legal requirements contained in those laws.

8 As used in this document, the phrase "dangerous behavior" refers to behavior that poses imminent danger of serious physical harm to self or others.

11. Every instance in which restraint or seclusion is used should be carefully and continuously and visually monitored to ensure the appropriateness of its use and safety of the child, other children, teachers, and other personnel.
12. Parents should be informed of the policies on restraint and seclusion at their child's school or other educational setting, as well as applicable Federal, State, or local laws.
13. Parents should be notified as soon as possible following each instance in which restraint or seclusion is used with their child.
14. Policies regarding the use of restraint and seclusion should be reviewed regularly and updated as appropriate.
15. Policies regarding the use of restraint and seclusion should provide that each incident involving the use of restraint or seclusion should be documented in writing and provide for the collection of specific data that would enable teachers, staff, and other personnel to understand and implement the preceding principles.

Following is additional information about each of the 15 principles.

1. **Every effort should be made to prevent the need for the use of restraint and for the use of seclusion.**

   All children should be educated in safe, respectful, and non-restrictive environments where they can receive the instruction and other supports they need to learn and achieve at high levels. Environments can be structured to greatly reduce, and in many cases eliminate, the need to use restraint or seclusion. SAMHSA notes in its *Issue Brief #1: Promoting Alternatives to the Use of Seclusion and Restraint*, that with leadership and policy and programmatic change, the use of seclusion and restraint can be prevented and in some facilities has been eliminated. One primary method is to structure the environment using a non-aversive effective behavioral system such as PBIS. Effective positive behavioral systems are comprehensive, in that they are comprised of a framework or approach for assisting school personnel in adopting and organizing evidence-based behavioral interventions into an integrated continuum that enhances academic and social behavioral outcomes for all students. The PBIS prevention-oriented framework or approach applies to all students, all staff, and all settings. When integrated with effective academic instruction, such systems can help provide the supports children need to become actively engaged in their own learning and academic success. Schools successfully implementing comprehensive behavioral systems create school-wide environments that reinforce appropriate behaviors while reducing instances of dangerous behaviors that may lead to the need to use restraint or seclusion. In

schools implementing comprehensive behavioral systems, trained school staff use preventive assessments to identify where, under what conditions, with whom, and why specific inappropriate behavior may occur, as well as implement de-escalation techniques to defuse potentially violent dangerous behavior. Preventive assessments should include (1) a review of existing records; (2) interviews with parents, family members, and students; and (3) examination of previous and existing behavioral intervention plans. Using these data from such assessments helps schools identify the conditions when inappropriate behavior is likely to occur and the factors that lead to the occurrence of these behaviors; and develop and implement preventive behavioral interventions that teach appropriate behavior and modify the environmental factors that escalate the inappropriate behavior. The use of comprehensive behavioral systems significantly decreases the likelihood that restraint or seclusion would be used, supports the attainment of more appropriate behavior, and, when implemented as described, can help to improve academic achievement and behavior.

2. **Schools should never use mechanical restraints to restrict a child's freedom of movement, and schools should never use a drug or medication to control behavior or restrict freedom of movement (except as authorized by a licensed physician or other qualified health professional).**

   Schools should never use mechanical restraints to restrict a child's freedom of movement. In addition, schools should never use a drug or medication to control behavior or restrict freedom of movement unless it is (1) prescribed by a licensed physician, or other qualified health professional acting under the scope of the professional's authority under State law; and (2) administered as prescribed by the licensed physician or other qualified health professional acting under the scope of the professional's authority under State law.

Schools should never use mechanical restraints to restrict a child's freedom of movement, and schools should never use a drug or medication to control behavior or restrict freedom of movement (except as authorized by a licensed physician or other qualified health professional).

3. **Physical restraint or seclusion should not be used except in situations where the child's behavior poses imminent danger of serious physical harm to self or others and other interventions are ineffective and should be discontinued as soon as imminent danger of serious physical harm to self or others has dissipated.**

   Physical restraint or seclusion should be reserved for situations or conditions where

there is imminent danger of serious physical harm to the child, other children, or school or program staff. These procedures should not be used except to protect the child and others from serious harm and to defuse imminently dangerous situations in the classroom or other non-classroom school settings (e.g., hallways, cafeteria, playground, sports field), and only should be used by trained personnel. Physical restraint or seclusion should not be used as a response to inappropriate behavior (e.g., disrespect, noncompliance, insubordination, out of seat) that does not pose imminent danger of serious physical harm to self or others, nor should a child be restrained and secluded simultaneously as this could endanger the child. In addition, planned behavioral strategies should be in place and used to: (1) de-escalate potentially violent dangerous behavior; (2) identify and support competing positive behavior to replace dangerous behavior; and (3) support appropriate behavior in class and throughout the school, especially if a student has a history of escalating dangerous behavior.

4. **Policies restricting the use of restraint and seclusion should apply to all children, not just children with disabilities.**

   Behavior that results in the rare use of restraint or seclusion -- that posing imminent danger of serious physical harm to self or others -- is not limited to children with disabilities, children with a particular disability, or specific groups of children (e.g., gender, race, national origin, limited English proficiency, etc.) without disabilities. Thus, to the extent that State and local policies address the use of restraint or seclusion, those policies, including assessment and prevention strategies, should apply to all children

in the school, all staff who work directly or indirectly with children, and across all settings under the responsibility of the school.

5. **Any behavioral intervention must be consistent with the child's rights to be treated with dignity and to be free from abuse.**

   Every child deserves to be treated with dignity, be free from abuse, and treated as a unique individual with individual needs, strengths, and circumstances (e.g., age, developmental level, medical needs). *The use of any technique that is abusive is illegal and should be reported to the appropriate authorities.* Schools should consider implementing an evidence-based school-wide system or framework of positive behavioral interventions and supports. Key elements of a school-wide system or framework include (1) universal screening to identify children at risk for behavioral problems; (2) use of a continuum of increasingly intensive behavioral and academic interventions for children identified as being at risk; (3) an emphasis on teaching and acknowledging school-wide and individual expected behaviors and social skills; and (4) systems to monitor the responsiveness of

individual children to behavioral and academic interventions. Increases in children's academic achievement and reductions in the frequency of disciplinary incidents can be realized when school-wide frameworks are implemented as designed and are customized to match the needs, resources, context, and culture of students and staff.

6. **Restraint or seclusion should never be used as punishment or discipline (e.g., placing in restraint for out-of-seat behavior), as a means of coercion, or retaliation, or as a convenience.**

   Restraint or seclusion should not be used as routine school safety measures; that is, they should not be implemented except in situations where a child's behavior poses imminent danger of serious physical harm to self or others and not as a routine strategy implemented to address instructional problems or inappropriate behavior (e.g., disrespect, noncompliance, insubordination, out of seat), as a means of coercion or retaliation, or as a convenience. Restraint or seclusion should only be used for limited periods of time and should cease immediately when the imminent danger of serious physical harm to self or others has dissipated. Restraint or seclusion should not be used (1) as a form of punishment or discipline (e.g., for out-of-seat behavior); (2) as a means to coerce, retaliate, or as a convenience for staff; (3) as a planned behavioral intervention in response to behavior that does not pose imminent danger of serious physical harm to self or others; or (4) in a manner that endangers the child. For example, it would be inappropriate to use restraint or seclusion for (1) failure to follow expected classroom or

   school rules; (2) noncompliance with staff directions; (3) the use of inappropriate language; (4) to "punish" a child for inappropriate behavior; or (5) staff to have an uninterrupted time together to discuss school issues.

7. **Restraint or seclusion should never be used in a manner that restricts a child's breathing or harms the child.**

   Prone (i.e., lying face down) restraints or other restraints that restrict breathing should never be used because they can cause serious injury or death. Breathing can also be restricted if loose clothing becomes entangled or tightened or if the child's face is covered by a staff member's body part (e.g., hand, arm, or torso) or through pressure to the abdomen or chest. Any restraint or seclusion technique should be consistent with known medical or other special needs of a child. School districts should be cognizant that certain restraint and seclusion techniques are more restrictive than others, and use the least restrictive technique necessary to end the threat of imminent danger of serious physical harm. A child's ability to communicate (including for those children who use only sign language or other

forms of manual communication or assistive technology) also should not be restricted unless less restrictive techniques would not prevent imminent danger of serious physical harm to the student or others. In all circumstances, the use of restraint or seclusion should never harm a child.

8. **The use of restraint or seclusion, particularly when there is repeated use for an individual child, multiple uses within the same classroom, or multiple uses by the same individual, should trigger a review and, if appropriate, a revision of behavioral strategies currently in place to address dangerous behavior; if positive behavioral strategies are not in place, staff should consider developing them.**

   In cases where a student has a history of dangerous behavior for which restraint or seclusion was considered or used, a school should have a plan for (1) teaching and supporting more appropriate behavior; and (2) determining positive methods to prevent behavioral escalations that have previously resulted in the use of restraint or seclusion. Trained personnel should develop this plan in concert with parents and relevant professionals by using practices such as functional behavioral assessments (FBAs) and behavioral intervention plans (BIPs). An FBA is used to analyze environmental factors, including any history of trauma (e.g., physical abuse), that contribute to a child's inappropriate (e.g., disrespect, noncompliance, insubordination, out-of-seat) behaviors. FBA data are used to develop positive behavioral strategies that emphasize redesigning environmental conditions, which may include changes in staff approaches and techniques, so that appropriate behavior is more likely to occur and inappropriate and dangerous behavior is less likely to occur.

   When restraint or seclusion is repeatedly used with a child, used multiple times within the same classroom, or used multiple times by the same individual, a review of the student's BIP should occur, the prescribed behavioral strategies should be modified, if needed; and staff training and skills should be re-evaluated. The need for the review is based on the individual needs of the child and the determination should include input from the family; a review could be necessitated by a single application of restraint or seclusion. This review may entail conducting another FBA to refine the BIP or examining the implementation of the current plan. If the student has a history of dangerous behavior and has been subjected to restraint or seclusion, a review and plan should be conducted prior to the student entering any program, classroom, or school. In all cases the reviews should consider not only the effectiveness of the plan, but also the capability of school staff to carry out the plan. Furthermore, if restraint or seclusion was used with a child who does not have an FBA and BIP, an FBA should be conducted and, if needed, a BIP developed and implemented that incorporates positive behavioral strategies for that child, including teaching positive behaviors. The long-term goal of FBAs and BIPs is to develop and implement preventive behavioral interventions, including increasing appropriate positive behaviors, that reduce the likelihood that restraint or seclusion will be used with a child in the future.

9. **Behavioral strategies to address dangerous behavior that results in the use of restraint or seclusion should address the underlying cause or purpose of the dangerous behavior.**

   Behavioral strategies, particularly when implemented as part of a school-wide program of positive behavioral supports, can be used to address the underlying causes of dangerous behavior and reduce the likelihood that restraint or seclusion will need to be used. Behavior does not occur in a vacuum but is associated with conditions, events, requirements, and characteristics of a given situation or setting. An FBA can identify the combination of antecedent factors (factors that immediately precede behavior)

   and consequences (factors that immediately follow behavior) that are associated with the occurrence of inappropriate behavior. Information collected through direct observations, interviews, and record reviews help to identify the function of the dangerous behavior and guide the development of BIPs. A complete BIP should describe strategies for (1) addressing the characteristics of the setting and events; (2) removing antecedents that trigger dangerous behavior; (3) adding antecedents that maintain appropriate behavior; (4) removing consequences that maintain or escalate dangerous behaviors; (5) adding consequences that maintain appropriate behavior; and (6) teaching alternative appropriate behaviors, including self regulation techniques, to replace the dangerous behaviors.

10. **Teachers and other personnel should be trained regularly on the appropriate use of effective alternatives to physical restraint and seclusion, such as positive behavioral interventions and supports and, only for cases involving imminent danger of serious physical harm, on the safe use of physical restraint and seclusion.**

    Positive behavioral strategies should be in place in schools and training in physical restraint and seclusion should first emphasize that every effort should be made to use positive behavioral strategies to prevent the need for the use of restraint and seclusion. School personnel working directly with children should know the school's policies and procedures for the safe use of physical restraint and seclusion, including both proper uses (e.g., as safety measures to address imminent danger of physical harm) and improper uses (e.g., as punishment or to manage behavior) of these procedures. In addition, school personnel should be trained in how to safely implement procedures for physical restraint and seclusion and only trained personnel should employ these interventions; as well as how to collect and analyze individual child data to determine the effectiveness of these procedures in increasing appropriate behavior and decreasing inappropriate behavior. These data

should inform the need for additional training, staff support, or policy change, particularly when data indicate repeated use of these interventions by staff.

School personnel also should receive training on the school's policies and procedures for the timely reporting and documentation of all instances in which restraint or seclusion are used. At a minimum, training on the use of physical restraint and seclusion and effective alternatives should be provided at the beginning and middle of each school year. However, such training should be conducted more often if there are enrolled students with a history or high incidence of dangerous behavior who may be subjected to physical restraint or seclusion procedures. In addition, school administrators should evaluate whether staff who engage in multiple uses of restraint or seclusion need additional training. All school personnel should receive comprehensive training on school-wide programs of positive behavioral supports and other strategies, including de-escalation techniques, for preventing dangerous behavior that leads to the use of restraint or seclusion. Training for principals and other school administrators should cover how to develop, implement, and evaluate the effectiveness of school-wide behavioral programs. Training for teachers, paraprofessionals, and other personnel who work directly with children should be ongoing and include refreshers on positive behavior management strategies, proper use of positive reinforcement, the continuum of alternative behavioral interventions, crisis prevention, de-escalation strategies, and the safe use of physical restraint and seclusion.

Behavioral strategies, particularly when implemented as part of a school-wide program of positive behavioral supports, can be used to address the underlying causes of dangerous behavior and reduce the likelihood that restraint or seclusion will need to be used.

Use and prevention training should be accompanied by regular supervised practice. Like quarterly fire drills, all staff members should be expected to regularly and frequently review and practice approaches to prevent the conditions that result in the use of restraint or seclusion and in the use of specific and planned physical restraint or seclusion procedures. A team of trained personnel should monitor practice sessions to check for adherence to and documentation of planned procedures.

11. **Every instance in which restraint or seclusion is used should be carefully and continuously and visually monitored to ensure the appropriateness of its use and the safety of the child, other children, teachers, and other personnel.**

    If restraint or seclusion is used, the child should be continuously and visually observed and monitored while he or she is restrained or placed in seclusion. Only school personnel who

have received the required training on the use of restraint and seclusion should be engaged in observing and monitoring these children. Monitoring should include a procedural checklist and recordkeeping procedures. School staff engaged in monitoring should be knowledgeable regarding (1) restraint and seclusion procedures and effective alternatives; (2) emergency and crisis procedures; (3) strategies to guide and prompt staff members engaged in restraint or seclusion procedures; and (4) procedures and processes for working as a team to implement, monitor, and debrief uses of restraint or seclusion. Monitoring staff should receive training to ensure that the use of physical restraint or seclusion does not harm the child or others, and that procedures are implemented as planned. For example, those observing the application of a restraint should confirm that the restraint does not cause harm to the child, such as restricting the child's breathing. Continuous monitoring of restraint includes, for example: (1) continuous assessment of staff and student status, including potential physical injuries; (2) termination of restraint or seclusion when imminent danger of serious physical harm to self or others has dissipated; (3) evaluation of how procedures are being implemented; and (4) consideration of opportunities for redirection and defusing the dangerous behavior. In developing procedures, States, districts, and schools should consider having school health personnel promptly assess the child after the imposition of restraints or seclusion.

Trained school staff should also inspect and prepare the seclusion area before a child is placed in seclusion. For example, the area should be free of any objects a child could use to injure him- or herself or others. School staff should either be inside the area or outside by a window or another adjacent location where staff can continuously observe the child and confirm that the child is not engaging in self-injurious behavior. When a child is in seclusion, trained school staff should constantly watch the child. Such observation and monitoring is critical in determining when the imminent danger of serious physical harm to self or others has dissipated so that the restraint or seclusion can be immediately discontinued. Proper observation and monitoring and written documentation of the use of restraint or seclusion helps to ensure the continued safety of the child being restrained or secluded as well as the safety of other children and school personnel.

12. **Parents should be informed of the policies on restraint and seclusion at their child's school or other educational setting, as well as applicable Federal, State or local laws.**

    All parents should receive, at least annually, written information about the policies and procedures for restraint and seclusion issued by the State, district, or school. This information should be included, for example, in the district's or school's handbook of policies and procedures or other appropriate and widely distributed school publications. Schools, districts, and States are encouraged to involve parents when developing policies and procedures on restraint and seclusion. These written descriptions should include the following: (1) a statement that mechanical restraint should not be used, that schools should never use a drug or medication to control behavior or restrict freedom of movement (except as authorized by a licensed

In addition, preventive strategies to reduce the likelihood that restraint or seclusion will need to be used with a child should be established, documented, and communicated to the child's parents.

physician or other qualified health professional), and physical restraint and seclusion should not be used except in situations where the child's behavior poses an imminent danger of serious physical harm to self or others and should be discontinued as soon as the imminent danger of serious physical harm to self or others has dissipated; (2) definitions of restraint and seclusion; (3) information on the procedures for determining when restraint or seclusion can and cannot be properly used in school settings; (4) information on the procedural safeguards that are in place to protect the rights of children and their parents; (5) a description of the alignment of a district's and school's policies and procedures with applicable State or local laws or regulations; (6) procedures for notifying parents when restraint or seclusion has been used with their child; and (7) procedures for notifying parents about any changes to policies and procedures on restraint or seclusion. If policy or procedural changes are made during the school year staff and family members should be notified immediately. In addition, preventive strategies to reduce the likelihood that restraint or seclusion will need to be used with a child should be established, documented, and communicated to the child's parents. Parents also should be encouraged to work with schools and districts to ensure planned behavioral strategies are in place and used to (1) de-escalate potentially violent dangerous behavior; (2) identify and support competing positive behavior to replace dangerous behavior; and (3) support appropriate behavior in class and throughout the school, especially if a student has a history of escalating dangerous behavior.

13. **Parents should be notified as soon as possible following each instance in which restraint or seclusion is used with their child.**

    Parents should be informed about the school's procedures for promptly notifying parents and documenting each time that restraint or seclusion is used with their child. The meaning of "as soon as possible" notification should be determined by the State, district, or school and included in the information on restraint and seclusion that is provided to parents. Documenting that parents have been notified as soon as possible, ideally on the same school day, when restraint or seclusion has been used ensures that parents are fully informed about their child's behavior and the school's response and helps parents participate as informed team members who can work with their child's teachers and other school staff to determine whether the behavioral supports at school and at home, including prevention and de-escalation strategies, are effective.

14. **Policies regarding the use of restraint and seclusion should be reviewed regularly and updated as appropriate.**

States, districts, and schools should not only establish and publish policies and procedures on the use of restraint and seclusion, but also should periodically review and update them as appropriate. This review should be conducted by a team (that includes parents) with expertise related to PBIS, and educating and supporting students with dangerous behaviors in schools and community settings. The review should consider and examine (1) available data on the use of these practices and their outcomes (i.e., the review should examine the frequency of the use of restraint and the use of seclusion across individual children, groups of children (e.g., gender, race, national origin, disability status and type of disability, limited English proficiency, etc.)), settings, individual staff, and programs and consider whether policies for restraint and seclusion are being applied consistently; (2) the accuracy and consistency with which restraint and seclusion data are being collected, as well as the extent to which these data are being used to plan behavioral interventions and staff training; (3) whether procedures for using these practices are being implemented with fidelity; (4) whether procedures continue to protect children and adults; and (5) whether existing policies and procedures for restraint and seclusion remain properly aligned with applicable State and local laws. The school should maintain records of its review of restraint and seclusion data and any resulting decisions or actions regarding the use of restraint and seclusion.

15. **Policies regarding the use of restraint and seclusion should provide that each incident involving the use of restraint or seclusion should be documented in writing and provide for the collection of specific data that would enable teachers, staff, and other personnel to understand and implement the preceding principles.**

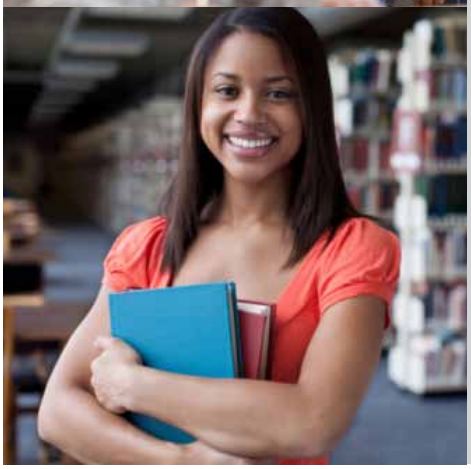
Each incident of the use of restraint and of the use of seclusion should be properly documented for the main purposes of preventing future need for the use of restraint or seclusion and creating a record for consideration when developing a plan to address the student's needs and staff training needs. For example, a school should maintain a written log of incidents when restraint or seclusion is used. Appropriate school staff should prepare a written log entry describing each incident, including details of the child's dangerous behavior, why this behavior posed an imminent danger of serious physical harm to self or others, possible factors contributing to the dangerous behavior, the effectiveness of restraint or seclusion in de-escalating the situation and staff response to such behavior. Best practices and existing State policies and

procedures indicate that documentation of each use of restraint or seclusion frequently includes (1) start and end times of the restraint or seclusion; (2) location of the incident; (3) persons involved in the restraint or seclusion; (4) the time and date the parents were notified; (5) possible events that triggered the behavior that led to the restraint or seclusion; (6) prevention, redirection, or pre-correction strategies that were used during the incident; (7) a description of the restraint or seclusion strategies that were used during the incident; (8) a description of any injuries or physical damage that occurred during the incident; (9) how the child was monitored during and after the incident; (10) the debriefing that occurred with staff following the incident; (11) the extent to which staff adhered to the procedural implementation guidelines (if established by the State, district, or school); and (12) follow-up that will occur to review or develop the student's BIP.

For individual children, these data should be periodically reviewed to determine whether (1) there are strategies in place to address the dangerous behavior at issue; (2) the strategies in place are effective in increasing appropriate behaviors; and (3) new strategies need to be developed, or current strategies need to be revised or changed to prevent reoccurrences of the dangerous behavior(s).

Data on the frequency of use of restraint and seclusion for all children should be periodically reviewed at school leadership meetings, grade-level meetings, and other meetings of school staff. Data to be reviewed at these meetings should include information, consistent with privacy laws, about the frequency and duration of restraint and seclusion incidents across individual children, groups of children (e.g., gender, race, national origin, disability status and type of disability, limited English proficiency, etc.), settings, individual staff, and programs, as well as the number and proportion of children who were restrained or placed in seclusion since the last meeting and for the year to date. Such reviews should be used to determine whether state, district, and school policies are being properly followed, whether procedures are being implemented as intended, and whether the school staff should receive additional training on the proper use of restraint and seclusion or PBIS. States, districts, and schools should consider making these data public, ensuring that personally identifiable information is protected.

States, districts, and schools should not only establish and publish policies and procedures on the use of restraint and seclusion, but also should periodically review and update them as appropriate.



Federal Agency Efforts to Address Concerns

To date, Federal efforts to address concerns about the use of restraint and seclusion in schools have included the following four interrelated policy initiatives: (1) articulating principles to emphasize that physical restraint and seclusion should not be used except to protect a child or others from imminent danger of serious physical harm; (2) developing a dear colleague letter and this Resource Document that will be used to provide States, districts, and schools with information related to the proper and improper use of restraint and seclusion; (3) collecting, analyzing, and publishing restraint and seclusion incident data from every State; and (4) publishing State regulations, policies, and guidance on the use of restraint and seclusion.

A summary of these Federal efforts is presented below.

DEPARTMENT OF EDUCATION EFFORTS

Letters from the Secretary

Secretary of Education Arne Duncan issued two letters articulating the Department's position on the use of restraint and seclusion.

The first letter was sent to Chief State School Officers on July 31, 2009 urging each State to review its current policies and guidelines on the use of restraint and seclusion in schools, and, if appropriate, to develop or revise them to ensure the safety of students. The letter highlighted a school-wide system of PBIS as an important preventive approach that can increase the capacity of school staff to support children with complex behavioral needs, thus reducing the instances that require the use of restraint and seclusion. The letter also explained that the Department would be contacting each State to discuss the State's plans to ensure the proper use of restraint and seclusion to protect the safety of children and others at school.

On December 8, 2009, the Secretary sent a letter to Chairman Dodd, Chairman Miller, and Representative McMorris Rodgers. This letter expressed the Department's appreciation of Congressional efforts to limit the use of restraint and seclusion. The letter also articulated a list of nine principles that the Secretary believed would be useful for Congress to consider in the context of any legislation on restraint and seclusion. Additionally, the letter informed Congress that the Department was reviewing information about each State's laws, regulations, policies, and guidance on restraint and seclusion.

Review of State Policies and Procedures

The Department's Regional Comprehensive Technical Assistance Centers collected information on the policies and procedures on restraint and seclusion in each of the 50 States, eight territories, Bureau of Indian Education, and District of Columbia. These data were summarized and presented in a public report released in February 2010 and updated through a review of State Web sites in August 2011.

The first letter was sent to Chief State School Officers on July 31, 2009 urging each State to review its current policies and guidelines on the use of restraint and seclusion in schools, and, if appropriate, to develop or revise them to ensure the safety of students.

Office for Civil Rights

The Department's OCR enforces certain civil rights laws prohibiting discrimination on the basis of race, color, national origin, sex, and disability by recipients of Federal financial assistance from the Department and certain public entities. In September 2009, OCR announced in the *Federal Register* that it would include, for the first time, questions on restraint and seclusion in the *Civil Rights Data Collection (CRDC)*. The CRDC now collects school- and district-level information about students in public schools that includes (1) the number of

students by race/ethnicity, sex, Limited English Proficiency (LEP) status, and disability status subjected to physical restraint; (2) the number of students by race/ethnicity, sex, LEP status, and disability status subjected to mechanical restraint; (3) the number of students by race/ethnicity, sex, LEP status, and disability status subjected to seclusion; and (4) the total number of incidents of physical restraint, mechanical restraint, and seclusion by disability status. The data collection tables can be found at http://ocrdata.ed.gov/Downloads.aspx. The CRDC restraint and seclusion data are available at http://ocrdata.ed.gov. The data were released in two parts, in September 2011 and March 2012.

Office of Special Education Programs

OSEP has a long history of investments in national centers and projects that support school-wide behavioral frameworks in schools. Notably, in 1997, OSEP began funding the Technical Assistance Center on Positive Behavioral Interventions and Supports. The ongoing work of this center has led to the development and implementation of School-wide Positive Behavioral Interventions and Supports (SWPBIS). Now widely used throughout the country, SWPBIS is a framework for organizing evidence-based behavioral interventions into an integrated, multi-tiered continuum that maximizes academic and behavioral outcomes for all students.

SWPBIS is organized around six core principles: (1) invest first in the prevention of the social behavior that impedes student academic and social success in schools; (2) build a positive whole-school social culture by defining, teaching, and acknowledging clearly defined behavioral expectations for all students; (3) establish and apply consistently a continuum of consequences for problem behavior that prevents the inadvertent reward of problem behavior; (4) establish and apply consistently a multi-tiered continuum of evidence-based behavioral practices that supports behavioral success for all students, especially those students with more complex behavior support challenges; (5) collect and use data continuously to screen and monitor progress of all students, make instructional and behavioral decisions, and solve problems; and (6) invest in the organizational infrastructure and capacity to enable effective, efficient, and relevant implementation of evidence-based practices. These six core principles offer school administrators, teachers, and other school staff practical guidelines for implementing comprehensive behavioral systems that help prevent the need to use restraint and seclusion in school.

A growing body of evaluation and experimental research supports the following conclusions about the impact of SWPBIS implementation. Schools throughout the country are able to adopt and implement SWPBIS practices. When SWPBIS is implemented as intended, schools experienced reductions in problem behaviors (e.g., behavior that results in office referrals, suspensions). SWPBIS implementation enhances the impact of effective instruction on

academic outcomes. When SWPBIS is implemented as intended, students and staff members report improved school safety and organizational health. Furthermore, SWPBIS is sustainable when initial implementation is done as intended.

OSEP's Technical Assistance Center on PBIS has assisted States and local districts with the implementation of SWPBIS in over 17,000 schools across the United States. Each of these schools has a team that has gone through, or is going through, formal training on SWPBIS practices. Teams benefit from local coaching provided by district school psychologists, social workers, counselors, administrators, and special educators. States and districts have been successful in implementing and sustaining SWPBIS by actively and formally developing State, local, and school capacity for coordination, training, coaching, and evaluation. This capacity building, in turn, supports continual improvement, effective outcomes, and efficient and accurate implementation, and maximizes student academic and behavior outcomes for all students. The center's technical assistance supports participating local districts and schools in identifying, adopting, and sustaining SWPBIS effectively.

DEPARTMENT OF HEALTH AND HUMAN SERVICES EFFORTS

Children's Health Act

Although restraint and seclusion have been used in mental health settings and other medical facilities for many years, these practices have become more controversial because of tragic outcomes such as deaths and serious injuries. In 2000, Congress passed the Children's Health Act, which required DHHS to draft regulations under Title V of the Public Health Service Act for the use of restraint and seclusion in medical facilities and in residential non-medical community-based facilities for children and youth. The Act set minimum standards for the use of restraint and seclusion, which stipulate that (1) restraint and seclusion are crisis response interventions and may not be used except to ensure immediate physical safety and only after less restrictive interventions have been found to be ineffective; (2) restraint and seclusion may not be used for discipline or convenience; (3) mechanical restraints are prohibited; (4) restraint or seclusion may be imposed only by individuals trained and certified in their application; and (5) children being restrained or secluded must be continuously monitored during the procedure. The Children's Health Act also required DHHS to draft regulations for States to use in training individuals in facilities covered under the Federal law.[9]

9 Regulations implementing Part H (Requirements Relating to the Rights of Residents of Certain Facilities) of Title V of the Public Health Service (PHS) Act have been promulgated, although regulations implementing Part I (Requirements relating to the rights of Residents of Certain Non-Medical, Community-Based Facilities for Children and Youth) of Title V of the PHS Act have not yet been promulgated. Moreover, regulations have not been issued regarding training of facility staff.

The Children's Health Act of 2000 (CHA) (Pub. L. 106-310) amended title V of the PHS Act to add two new parts (Parts H and I) that established minimum requirements for the protection and the promotion of rights of residents of certain facilities to be free from the improper use of seclusion or restraint. Consistent with section 3207 of the Children's Health Act, the Centers for Medicare and Medicaid Services (CMS) issued regulations setting forth patient rights to be free of medically unnecessary restraint and seclusion in several types of health care facilities and programs, including: hospitals, in a final rule published at 71 Fed. Reg. 71378 (Dec. 8, 2006) that also applies to critical access hospitals; hospices, in a final rule published at 73 Fed. Reg. 32088 (June 5, 2008); Medicaid managed care, in a final rule published at 67 Fed. Reg. 40989 (June 14, 2002); programs of all-inclusive care for the elderly (PACE), in a final rule published at 71 Fed. Reg. 71244 (Dec. 8, 2006); and psychiatric residential treatment facilities for individuals under age 21, in an interim final rule published at 66 Fed. Reg. 7148 (Jan. 22, 2001). CMS has also proposed regulations governing the use of restraint and seclusion in Community Mental Health Centers, at 76 Fed. Reg. 35684 (June 17, 2011).

SAMHSA

As part of SAMHSA's continuing efforts to provide guidance on the Children's Health Act, in 2002, the agency developed the Six Core Strategies[10] model, which defines specific interventions to prevent or reduce the use of restraint and seclusion in healthcare settings. This model curriculum includes the following six core components:

- Leadership toward organizational change
- The use of data to inform practice
- Workforce Development: In-service training, supervision, and mentoring
- Use of primary prevention tools
- Supporting roles for persons served and advocates in programs
- Debriefing tools

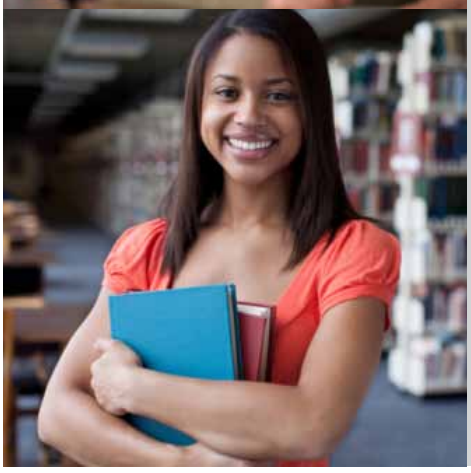
While mainly used for training in healthcare settings, these six components have been found to be applicable in school settings. Furthermore, the policy concerns exemplified in these core components have contributed to the Department's interagency collaboration with SAMHSA to address the use of restraint and seclusion in school settings across the country.

10 NASMHPD published the first training curriculum on *Six Core Strategies© to Reduce the Use of Seclusion and Restraint in Inpatient Facilities* in 2002. Since then, the Six Core Strategies© have been formally evaluated, and the evidence indicates they likely meet criteria for inclusion on SAMHSA's National Registry of Evidence-Based Programs and Practices. http://www.grafton.org/Newsletter/art%20lebel.pdf

LeBel, J; Huckshorn, K.A.; Caldwell, B. (2010). *Restraint use in residential programs: Why are the best practices ignored?* Child Welfare 89(2), 169-187.



Attachment A



Revised Summary of Restraint and Seclusion Statutes, Regulations, Policies and Guidance, by State: Information as Reported to the Regional Comprehensive Centers and Gathered from Other Sources

This attachment is intended to be accessed through the Internet. If this document is being printed, pages 30-32 will not contain URLs.

State or District	Statutes and Regulations Addressing Restraint and Seclusion[+]	Policies and Guidance Addressing Restraint and Seclusion[x]
Alabama	No state statute or regulations addressing seclusion and restraint.	Please see State Web site for further information.
Alaska	Please see State Web site for further information.	No policies or guidance addressing seclusion and restraint.
Arizona	No state statute or regulations addressing seclusion and restraint.	Please see State Web site for further information.
Arkansas	Please see State Web site for further information.	Please see State Web site for further information.
California	Please see State Web site for further information.	Please see State Web site for further information.
Colorado	Please see State Web site for further information.	Please see State Web site for further information.
Connecticut	Please see State Web site for further information.	Please see State Web site for further information.
Delaware	Please see State Web site for further information.	Please see State Web site for further information.
District of Columbia	Please see District Web site for further information.	Please see District Web site for further information.
Florida	Please see State Web site for further information.	Please see State Web site for further information.
Georgia	Please see State Web site for further information.	Please see State Web site for further information.
Hawaii	Please see State Web site for further information.	Please see State Web site for further information.
Idaho*	Please see State Web site for further information.	Please see State Web site for further information.
Illinois	Please see State Web site for further information.	Please see State Web site for further information.
Indiana	No state statute or regulations addressing seclusion and restraint.	Please see State Web site for further information.
Iowa	Please see State Web site for further information.	Please see State Web site for further information.
Kansas	No state statute or regulations addressing seclusion and restraint.	Please see State Web site for further information.
Kentucky	No state statute or regulations addressing seclusion and restraint.	Please see State Web site for further information.
Louisiana*	Please see State Web site for further information.	No policies or guidance addressing seclusion and restraint.

State or District	Statutes and Regulations Addressing Restraint and Seclusion[+]	Policies and Guidance Addressing Restraint and Seclusion[x]
Maine	Please see State Web site for further information.	Please see State Web site for further information.
Maryland	Please see State Web site for further information.	Please see State Web site for further information.
Massachusetts	Please see State Web site for further information.	Please see State Web site for further information.
Michigan	Please see State Web site for further information.	Please see State Web site for further information.
Minnesota	Please see State Web site for further information.	Please see State Web site for further information.
Mississippi	No state statute or regulations addressing seclusion and restraint.	Please see State Web site for further information.
Missouri	Please see State Web site for further information.	No policies or guidance addressing seclusion and restraint.
Montana	Please see State Web site for further information.	Please see State Web site for further information.
Nebraska	Please see State Web site for further information.	Please see State Web site for further information.
Nevada	Please see State Web site for further information.	No policies or guidance addressing seclusion and restraint.
New Hampshire	Please see State Web site for further information.	Please see State Web site for further information.
New Jersey*	No state statute or regulations addressing seclusion and restraint.	Please see State Web site for further information.
New Mexico	No state statute or regulations addressing seclusion and restraint.	Please see State Web site for further information.
New York	Please see State Web site for further information.	Please see State Web site for further information.
North Carolina	Please see State Web site for further information.	Please see State Web site for further information.
North Dakota	Please see State Web site for further information.	No policies or guidance addressing seclusion and restraint.
Ohio	No state statute or regulations addressing seclusion and restraint.	Please see State Web site for further information.
Oklahoma*	No state statute or regulations addressing seclusion and restraint.	Please see State Web site for further information.
Oregon	Please see State Web site for further information.	Please see State Web site for further information.

State or District	Statutes and Regulations Addressing Restraint and Seclusion[+]	Policies and Guidance Addressing Restraint and Seclusion[x]
Pennsylvania	Please see State Web site for further information.	Please see State Web site for further information.
Rhode Island	Please see State Web site for further information.	No policies or guidance addressing seclusion and restraint.
South Carolina	No state statute or regulations addressing seclusion and restraint.	Please see State Web site for further information.
South Dakota*	No state statute or regulations addressing seclusion and restraint.	No policies or guidance addressing seclusion and restraint.
Tennessee	Please see State Web site for further information.	Please see State Web site for further information.
Texas	Please see State Web site for further information.	Please see State Web site for further information.
Utah	Please see State Web site for further information.	No policies or guidance addressing seclusion and restraint.
Vermont	Please see State Web site for further information.	Please see State Web site for further information.
Virginia	Please see State Web site for further information.	Please see State Web site for further information.
Washington	Please see State Web site for further information.	Please see State Web site for further information.
West Virginia	No state statute or regulations addressing seclusion and restraint.	Please see State Web site for further information.
Wisconsin	Please see State Web site for further information.	Please see State Web site for further information.
Wyoming*	Please see State Web site for further information.	No policies or guidance addressing seclusion and restraint.

NOTE: In August 2009, the Regional Comprehensive Centers conducted research on each state's laws, regulations, guidance, and policies regarding the use of restraint and seclusion in schools and confirmed the information obtained with the states. The information in this report was updated by researchers at the American Institutes for Research in May 2012 and was current as of this date.

[+] Proposed or enacted laws and supporting regulations describing the implementation of the laws, originating from the State legislature.

[x] Statements or documents that set out the state views and expectations related to school district duties and responsibilities, originating from the State executive office.

[*] State restraint and seclusion statutes, regulations, policies, or guidance are still in development.



Attachment B



Restraint and Seclusion: Resource Document Resources with Annotations

This document contains links to Web sites and information created and maintained by public and private organizations other than the U.S. Department of Education. This information is provided for the reader's convenience. The U.S. Department of Education does not control or guarantee the accuracy, relevance, timeliness, or completeness of this outside information. Some of this information is presented as examples of information that may be relevant. Further, the inclusion of information or addresses, or Web sites for particular items does not reflect their importance, nor is it intended to endorse any views expressed, or products or services offered.

Federal Resources

Duncan, A. (2009, July 31). Letter from Education Secretary Arne Duncan to the Council of Chief State School Officers (CCSSO). Retrieved from http://www2.ed.gov/policy/elsec/guid/secletter/090731.html

In this letter to the CCSSO, Education Secretary Arne Duncan responds to the testimony issued by the Government Accountability Office on "Seclusions and Restraints: Selected Cases of Death and Abuse at Public and Private Schools and Treatment Centers." He encourages the CCSSO to develop or review and, if appropriate, revise their State policies and guidelines to ensure that every student in every school under their jurisdiction is safe and protected from being unnecessarily or inappropriately restrained or secluded. He also urges them to publicize these policies and guidelines so that administrators, teachers, and parents understand and consent to the limited circumstances under which these techniques may be used; ensure that parents are notified when these interventions do occur; provide the resources needed to successfully implement the policies and hold school districts accountable for adhering to the guidelines; and to have the revised policies and guidance in place prior to the start of the 2009–2010 school year.

Duncan, A. (2009, December 8). Letter from Education Secretary Arne Duncan to Chairman Christopher J. Dodd, Chairman George Miller, and Representative Cathy McMorris Rodgers. Retrieved from http://www2.ed.gov/policy/gen/guid/secletter/091211.html

In this letter, Education Secretary Arne Duncan applauds the efforts of Chairman Christopher J. Dodd, Chairman George Miller, and Representative Cathy McMorris Rodgers to develop legislation to limit the use of physical restraint and seclusion in schools and other educational settings that receive Federal funds, except when it is necessary to protect a child or others from imminent danger. He reports that the U.S. Department of Education has identified a number of principles that may be useful for Congress to consider in the context of any legislation on this issue. These principles are listed in the letter.

The following legislation was introduced in the 111th and 112th Congresses, concerning limitations on the use of restraint and seclusion in schools and other educational settings:

- S. 2020, 112th Congress
- H.R. 1381, 112th Congress
- S. 3895, 111th Congress
- H.R. 4247, 111th Congress
- S. 2860, 111th Congress

Jones, N. L. & Feder, J. (2010). *The use of seclusion and restraint in public schools: The legal issues.* Washington, DC: Congressional Research Service. Retrieved from http://assets.opencrs.com/rpts/R40522_20101014.pdf

This research report was prepared by the Congressional Research Service for the members and committees of Congress. It was prepared because of congressional interest in the use of seclusion and restraint in schools, including passage of H.R. 4247 and the introduction of S. 2860, 111th Congress, first session. This report focuses on the legal issues concerning the use of seclusion and restraint in schools, including their application both to children covered by the

Individuals with Disabilities Education Act (IDEA) and to those not covered by IDEA. It refers to reports that document instances of deaths and injuries resulting from the use of seclusion or restraints in schools. This report notes that the IDEA requires a free appropriate public education for children with disabilities, and an argument could be made that some uses of seclusion and restraint would violate this requirement. The passage of S. 2860 in the Senate would establish minimum safety standards in schools to prevent and reduce the inappropriate use of restraint and seclusion.

Kutz, G. D. (2009). *Seclusions and restraints: Selected cases of death and abuse at public and private schools and treatment centers.* (GAO-09-719T). Washington, DC: U.S. Government Accountability Office, Forensic Audits and Special Investigations. Retrieved from http://www.gao.gov/new.items/d09719t.pdf

This report addresses the recent testimony of the Government Accountability Office (GAO) before the Congressional Committee on Education and Labor regarding allegations of death and abuse at residential programs for troubled teens. It cites other reports that indicate that vulnerable children are being abused in other settings, through the use of restraint and seclusion in schools. This report provides an overview of seclusion and restraint laws applicable to children in public and private schools, discusses whether allegations of student death and abuse from the use of these methods are widespread, and examines the facts and circumstances surrounding cases in which a student died or suffered abuse as a result of being secluded or restrained. The report is a review of Federal and State laws and abuse allegations from advocacy groups, parents, and the media from the past two decades. The report found no Federal law restricting the use of seclusion and restraint, and found hundreds of cases of alleged abuse and death related to the use of these methods on school children; examples are provided.

U.S. Department of Education. (2010) *Summary of seclusion and restraint statutes, regulations, policies and guidance, by State and territory: Information as reported to the regional Comprehensive Centers and gathered from other sources.* Washington, DC: Author. Retrieved from http://www2.ed.gov/policy/seclusion/seclusion-state-summary.html

This summary documents the results of the Department of Education's 2009 request that the States report on their laws, regulations, guidance, and policies regarding the use of seclusion and restraints in schools. The document includes the descriptive information as verified by each State and territory, and a summary of this information.

U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Jan Lebel (2011) *The business case for preventing and reducing restraint and seclusion use.* Washington, DC: Retrieved from http://store.samhsa.gov/shin/content//SMA11-4632/SMA11-4632.pdf

This document asserts that restraint and seclusion are violent, expensive, largely preventable, adverse events. The document also makes a number of claims, including the following: (1) the rationale for the use of restraint and seclusion is inconsistently understood and contribute to a cycle of workplace violence that can reportedly claim as much as 23 to

50 percent of staff time, account for 50 percent of staff injuries, increase the risk of injury to consumers and staff by 60 percent, and increase the length of stay, potentially setting recovery back at least 6 months with each occurrence; (2) restraint and seclusion increases the daily cost of care and contributes to significant workforce turnover reportedly ranging from 18 to 62 percent, costing hundreds of thousands of dollars to several million; (3) restraint and seclusion procedures raise the risk profile to an organization and incur liability expenses that can adversely impact the viability of the service; (4) many hospitals and residential programs, serving different ages and populations, have successfully reduced their use and redirected existing resources to support additional staff training, implement prevention-oriented alternatives, and enhance the environment of care; and (5) significant savings result from reduced staff turnover, hiring and replacement costs, sick time, and liability-related costs.

Associated Resources

American Association of School Administrators. (2010, March 2). Letter to U.S. House of Representatives. Retrieved from http://www.aasa.org/uploadedFiles/Policy_and_Advocacy/files/HR4247LetterMarch2010.pdf

In this letter to the U.S. House of Representatives, the American Association of School Administrators (AASA) urges the House not to pass restraint and seclusion measure H.R. 4247. The AASA states that the need to establish these particular Federal regulations for seclusion and restraint has not been established by objective, carefully gathered and analyzed data, and that the voices of teachers and administrators have not been heard. The letter notes that the Office for Civil Rights within the U.S. Department of Education is preparing to gather more objective information, and asks the House to wait for these objective results. The AASA also describes the report recently released by the U.S. Department of Education, which confirms that 31 States already have policies in place to oversee the use of seclusion and restraint and 15 more are in the process of adopting policies and protections. Given this substantial State action, AASA questions the need for Federal involvement on this issue. Finally, the letter protests the tone of H.R. 4247, which it describes as relentlessly negative toward teachers and administrators.

The Council for Children with Behavioral Disorders. (2009). *Physical restraint and seclusion procedures in school settings*. Arlington, VA: Council for Exceptional Children. Retrieved from http://www.ccbd.net/sites/default/files/CCBD%20Summary%20on%20Restraint%20and%20Seclusion%207-8-09.pdf

This document is a summary of policy recommendations from two longer and more detailed documents available from the Council for Children with Behavioral Disorders (CCBD) regarding the use of physical restraint and seclusion procedures in schools. CCBD is the division of the Council for Exceptional Children (CEC) committed to promoting and facilitating the education and general welfare of children and youth with emotional or behavioral disorders. In this document, CCBD states that while restraint and seclusion can be effective when dealing with children with behavioral issues, they should not be implemented except as a last resort when a child or others are in immediate danger. CCBD further recommends that new legislation or regulations be established to formally require that data on restraint and seclusion be reported to outside agencies, such as State or provincial departments of education.

The document also notes that additional research is needed on the use of physical restraint and seclusion with children or youth across all settings.

Dunlap, G., Ostryn, C., & Fox, L. (2011). *Preventing the Use of Restraint and Seclusion with Young Children: "The Role of Effective, Positive Practices". Issue Brief.* Technical Assistance Center on Social Emotional Intervention for Young Children. University of South Florida, 13301 North Bruce B Downs Boulevard MHC2-1134, Tampa, FL 33612. Web site: http://www.challengingbehavior.org. Retrieved from http://www.eric.ed.gov/ERICWebPortal/contentdelivery/servlet/ERICServlet?accno=ED526387

The purpose of this document is to review what constitutes restraint and seclusion, what should be done as an alternative, and discuss positive strategies that can be used to prevent behaviors that could lead to considerations of these invasive and potentially-dangerous practices.

Hague, B. (2010, February 18). *Stricter standards sought for use of seclusion and restraint by schools.* (Recording). Wisconsin Radio Network. Retrieved from http://www.wrn.com/2010/02/stricter-standards-sought-for-use-of-seclusion-and-restraint-by-schools/

This interview discusses a Wisconsin State capitol hearing on how best to deal with students with special needs who become disruptive. The organization, Disability Rights Wisconsin, claims that the State's department of education is not doing enough to curtail excessive use of restraint and seclusion; the State department of education disagrees. The interview reports that the State Senate is discussing legislation to restrict the use of restraint and seclusion, but the department of education is arguing that this legislation will go too far and prevent teachers and administrators from maintaining a safe classroom. The Senate intends to require that all teachers and other personnel be required to receive training in PBIS to reduce the need for seclusion and restraint, and claims that this will make schools safer and improve academic performance. The piece also notes concerns about the costs to districts of implementing additional training, as well as potential lawsuits.

Horner, R. & Sugai, G. (2009). *Considerations for seclusion and restraint use in school-wide positive behavior supports.* Eugene, OR: OSEP Technical Assistance Center on Positive Behavioral Interventions and Support. Retrieved from http://www.pbis.org/common/pbisresources/publications/Seclusion_Restraint_inBehaviorSupport.pdf

The PBIS Center defines seclusion and restraint as safety procedures in which a student is isolated from others (seclusion) or physically held (restraint) in response to serious problem behavior that places the student or others at risk of injury or harm. This document expresses concern regarding these procedures being prone to misapplication and abuse, potentially placing students at equal or more risk than their problem behavior. The specific concerns are listed and recommendations are made to promote effective policies. School-wide positive behavior support (SWPBS) is one of the major recommendations, defined as a systems approach to establishing the whole-school social culture and intensive individual behavior supports needed for schools to achieve social and academic gains while minimizing problem

behavior for all students. SWPBS emphasizes four integrated elements: socially valued and measurable outcomes, empirically validated and practical practices, systems that efficiently and effectively support implementation of these practices, and continuous collection and use of data for decision-making. These elements are described in detail along with supporting research.

The Legal Center for People with Disabilities and Older People. (2007). *Public report of an investigation into the improper use of restraint and/or seclusion of students with disabilities at Will Rogers elementary school.* Denver, CO: Author. Retrieved from http://66.147.244.209/~tashorg/wp-content/uploads/2011/01/The-Legal-Center_PA-Investigation.pdf

The Legal Center for People with Disabilities and Older People (the Legal Center) is the Protection and Advocacy System for Colorado. This report presents the results of the investigation conducted by the Legal Center into the circumstances surrounding the use of seclusion and restraint of five elementary school students. The Legal Center received complaints that students with a range of emotional, mental health, and developmental disabilities were subjected to improper use of restraint and seclusion by school staff at Will Rogers Elementary School. The information produced in the course of this investigation supports the conclusion that the five students were repeatedly subjected to improper restraint and seclusion in violation of the Colorado Department of Education restraint/seclusion rules. Based on this, the Legal Center recommends a number of actions be taken by District 11 and staff at Will Rogers Elementary school.

Morrison, L. & Moore, C. (2007). *Restraint and seclusion in California schools: A failing grade.* Oakland, CA: Protection & Advocacy, Inc. (PAI). Retrieved from http://www.disabilityrightsca.org/pubs/702301.htm

PAI conducted an in-depth investigation into allegations of abusive restraint and seclusion practices involving seven students in five public schools and one non-public school in California. The investigations revealed both the failure of school personnel to comply with existing regulations and the inability of current law to sufficiently regulate the use of these dangerous practices. PAI released this report to reinforce compliance with current regulatory requirements and to challenge schools and the education system to bring standards regarding behavioral restraint and seclusion of students into line with current practices in all other settings. The report notes that there are strict guidelines limiting the use of restraint and seclusion to extreme situations where there is an imminent risk of serious physical harm to an individual and only for the duration and to the extent necessary to protect the individual.

National Association of State Mental Health Program Directors (NASMHPD): Huckshorn, K. (2005). *Six core strategies to reduce the use of seclusion and restraint planning tool.* Retrieved from http://www.hogg.utexas.edu/uploads/documents/SR_Plan_Template.pdf

This planning tool guides the design of a seclusion and restraint reduction plan that incorporates the use of a prevention approach, includes six core strategies to reduce the use of seclusion and restraint described in the NASMHPD curriculum, and ascribes to the principles of continuous quality improvement. It

may also be used as a monitoring tool to supervise implementation of a reduction plan and identify problems, issues barriers and successes.

National Disability Rights Network. (2009, January). *School is not supposed to hurt: Investigative report on abusive restraint and seclusion in schools.* Retrieved from http://www.napas.org/images/Documents/Resources/Publications/Reports/SR-Report2009.pdf (Updated in 2010)

This report is divided into two sections. The first identifies the problems attributed to restraint or seclusion. It includes a "Chronicle of Harm" detailing treatment of children of all ages and in every corner of the nation – urban, suburban, and rural, in wealthy and poor school districts, as well as in private schools. It outlines the problems associated with the use of restraint or seclusion, and details the proven risks to children associated with the use of these aversive techniques. Contributing factors are identified, such as the lack of appropriate training for teachers and other school personnel in the use of positive behavioral supports that address children's behavioral and other issues in a humane and effective way.

The second section of this report proposes solutions to the use of restraint or seclusion by highlighting the best practices in education and the use of positive behavioral supports. Included is a catalogue of advocacy activities that have been undertaken by P&As to protect children with disabilities. These activities range from educating parents, students, and school personnel, to investigating and litigating when abuses occur, to working for strong State and federal laws to protect these vulnerable children. An update to this report and follow-up letter are available at: National Disability Rights Network, Not Supposed to Hurt: Update on Progress in 2009, at http://ndrn.org/images/Documents/Resources/Publications/Reports/School-is-Not-Supposed-to-Hurt-NDRN.pdf

National Disability Rights Network, School Is Not Supposed to Hurt: The U.S. Department of Education Must Do More to Protect School Children from Restraint and Seclusion, March 2012, *at* http://ndrn.org/images/Documents/Resources/Publications/Reports/School_is_Not_Supposed_to_Hurt_3_v7.pdf

Samuels, C. A. (2009). Use of seclusion, restraints on students at issue: Watchdog agency preparing report on practices. *Education Week, 28*(29), 6. Retrieved from http://www.edweek.org/ew/articles/2009/04/17/29restrain.h28.html

This article reports that many States lack policies related to seclusion or restraint in schools, and that the Federal government does not require record-keeping on the practices. The article details the efforts of advocacy groups for people with disabilities to keep the issue of restraint and seclusion as a priority for the Federal government and the national media. Organizations are trying to get Federal economic stimulus funds as a source of money to pay for the professional development that they say would foster a positive school environment. Advocates believe that such training for educators would prevent problems from escalating to the point that secluding students or physically restraining them is needed. Advocates, as well as educational organizations, agree that more training is necessary to reduce the use of restraint and seclusion in school. The article presents a discussion by several organizations' representatives on ways to provide this training.

Shank, C., Greenberg, J., & Lebens, M. (2011). *Keep school safe for everyone: A report on the restraint and seclusion of children with disabilities in Oregon schools*. Portland, OR: Disability Rights Oregon is the Protection & Advocacy System for Oregon. Retrieved from http://www.disabilityrightsoregon.org/results/DRO-Keep%20School%20Safe%20for%20Everyone%20Report.pdf

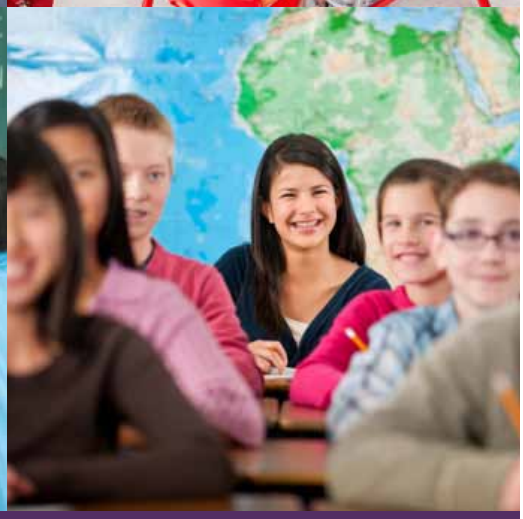
The Disability Rights Oregon (DRO) gathered information from parents and schools about the use of physical restraint and seclusion in Oregon and provided policy recommendations on the use of these practices in the State. The DRO report found that the use of physical restraint and seclusion varied considerably across Oregon school districts. For example, some Oregon districts had adopted appropriate policies and were trying to follow them. Other districts, however, had not adopted any policies at all. Furthermore, many Oregon districts were found to have policies that were inconsistent with their own administrative rules. This report also details stories of Oregon children who were restrained and secluded and had experienced psychological and physical injuries resulting from the use of these practices at school. In addition, the report provides a list of policy recommendations on physical restraint and seclusion. The report notes that its recommended policies are generally consistent with policies contained in Federal legislation. The DRO concludes that its recommended policies will provide enforceable minimum safety standards, provide administrative review and independent oversight, and help make Oregon's schools safe for all students and staff.

Southern Tier Independence Center, Disabled Abuse Coalition. (2009). *Abuse and neglect of children with disabilities in New York non-residential public schools*. Binghamton, NY: Author. Retrieved from http://www.ndrn.org/images/Documents/Issues/Restraint_and_Seclusions/NDRN_Children_with_Disabilities_2009.pdf

This document responds to reports by families and advocates indicating a pattern of discriminatory treatment toward children with disabilities who are neglected or abused in non-residential public schools in New York. The document notes that, under New York law, these schools are allowed to use physical restraints, including straps, "take-downs," and "time-out rooms," for unlimited periods of time as punishment for minor infractions, including any behavior that may "disrupt the order of the school." However, such restraints are often used by poorly trained staff, and the potential for serious injury is high. The document states that experts in special education universally agree that restraints should not be used except as emergency measures for children who are immediately and seriously dangerous to themselves or others, and that use of restraints under those circumstances should trigger an immediate comprehensive response to investigate antecedents to the problem behavior and develop proactive plans to address it. Thus, the STIC argues that New York State needs to enact stringent legislation to regulate the use of physical restraint, provide training requirements for public non-residential school aides that are strictly enforced, and empower State and local police and child-protective authorities to immediately accept and promptly investigate all complaints of abuse and neglect and to file criminal charges when warranted.







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Minnesota Department of **Human Services**

Disability Services Division

Synopsis of Scope Applicability and Purpose of Various Minnesota Statutes and Rules As Well As Arizona Policy and Federal Laws On The Use of Restrictive Aversive/Deprivation Procedures

Synopsis of Scope Applicability and Purpose of Various Minnesota Statutes and Rules As Well As Arizona Policy and Federal Laws On The Use of Restrictive Aversive/Deprivation Procedures				**Website References** **Rule # 40 -** https://www.revisor.mn.gov/rules/?id=9525.2700 **M.S. 245.825 -** https://www.revisor.mn.gov/statutes/?id=245.825			
POLICY	**PEOPLE**	**PROVIDERS**	**PURPOSE**	**POSITIVE**	**EXEMPT**	**RESTRICTIVE PERMITTED/ CONTROLLED**	**PROHIBITED**
Rule # 40 MN Rules, parts 9525.2700 to 9525.2810 & **MN Statutes 245.825**	•Applies to People with developmental disabilities. •Does not apply to committed patients residing at state hospitals or regional. treatment centers. • Does not apply to Intensive Residential Rehabilitative Mental Health Services and Residential Crisis Stabilization Services.	Providers whose services are DHS licensed under Minnesota Statutes, Chapter 245A, services.	•Sets standards that govern the use of aversive and deprivation procedures on a planned and emergency use basis. •Encourages the use of positive approaches as an alternative to aversive or deprivation procedures. •Requires documentation that positive approaches have been tried and have been unsuccessful as a condition of implementing an aversive or deprivation procedure.	•comprehensive functional assessment analyses. • Outlines required components of effective positive reinforcement behavioral program development. •Establishes schedules of evaluative monitoring and obtaining informed consent.	•corrective feedback. •physical contact & prompts (e.g., hand-over-hand, graduated guidance, physical escorts, etc.). •temporary interruption or contingent observation. •token or point response-cost. Procedures. •medical mechanical restraint.	•Physical (Manual) Restraint •Mechanical Restraint •Room Time-Out •Exclusionary Time-Out •Positive Practice Overcorrection •Restitution Overcorrection •Partial Sensory Restrictions (hand in front of eyes or music/sound at normal volume levels through headphones) •Response-Cost Deprivations •Faradic Shock (court ordered)	•Practices that constitute physical, sexual & psych abuse or neglect. •Restricting access to normative & needed goods and services. •Deny access to family and legal representation. •Fully depriving sensory restrictions. •Intense aversive stimuli. •bodily pain-inducing techniques. •Seclusion, •Emergency use of room-time-out and faradic shock.

Synopsis of Scope Applicability and Purpose of Various Minnesota Statutes and Rules As Well As Arizona Policy and Federal Laws On The Use of Restrictive Aversive/Deprivation Procedures				**Website References** M.S. 245.8261 - https://www.revisor.mn.gov/statutes/?id=245.8261			
POLICY	**PEOPLE**	**PROVIDERS**	**PURPOSE**	**POSITIVE**	**EXEMPT**	**RESTRICTIVE PERMITTED/ CONTROLLED**	**PROHIBITED**
MN Statutes, section 245.8261	•Children with mental health issues.	• Applies to providers of the following mental health services for children: emergency services, family community support services, day treatment services, therapeutic support services, foster care, professional home-based family treatment and mental health crisis services. {MN Statutes, sections 245.4871, 245.4879, 245.488 & 245.4884}.	•Establishes requirements for providers to meet in order to use restrictive procedures within a written restrictive procedures plan or on an emergency use basis. •Requires the provider to monitor and control the use of restrictive procedures; •Requires every 2 year, extensive professional staff training. •Requires levels of reviews, reporting and obtaining informed consent.	•Assessment of needs & behavior of children. •Engaging in relationship-building. •Alternatives to restrictive procedures, including techniques to identify events and environmental factors that may trigger behavioral escalation. •De-escalation interventions. •Avoiding power struggle methods.	•Corrective feedback or verbal prompts. •Physical contact & physical prompts. (graduated guidance and physical escorts, etc.). • Manual or mechanical medical restraints.	•Physical escort •Physical holding •Mechanical restraints (time-limited and only in emergencies) •Time out •Seclusion	•Practices that constitute physical, sexual & psych abuse or neglect. •Restricting access to normative & needed goods and services. •Deny access to family and legal representation. •Fully depriving sensory restrictions. •Intense aversive stimuli. •bodily pain-inducing techniques. •using restrictive procedures as punishment or convenience methods for staff.

Synopsis of Scope Applicability and Purpose of Various Minnesota Statutes and Rules As Well As Arizona Policy and Federal Laws On The Use of Restrictive Aversive/Deprivation Procedures				**Website References** **Rule, part 2960.710 -** https://www.revisor.mn.gov/rules/?id=2960.0710			
POLICY	**PEOPLE**	**PROVIDERS**	**PURPOSE**	**POSITIVE**	**EXEMPT**	**RESTRICTIVE PERMITTED/ CONTROLLED**	**PROHIBITED**
MN Rules, parts 2960.710	•Children Residents of licensed and certified DHS residential facilities and Department of Corrections correctional facilities	•Children Residential Facilities licensed and certified under MN Rules, Chapter 2960 and, parts 2960.710.	•Establishes requirements for providers to meet in order to use restrictive procedures within a written restrictive procedures plan or on an emergency use basis. •Requires the provider to monitor and control the use of restrictive procedures. •Requires extensive professional staff training. •Requires levels of reviews and reporting.	•Assess needs & behaviors of children. •Engage in relationship-building. •Alternatives to restrictive procedures. •De-escalation interventions. •Avoiding power struggle methods.	•**N/A** none listed in 2960.710.	•Only DHS licensed and certified facilities can use: A. physical escort; B. physical holding; C. seclusion; and D. the limited use of mechanical restraint only for transporting a resident. •Department of Corrections licensed and certified facilities: A. physical escort; B. physical holding; C. seclusion; D. mechanical restraints; and E. disciplinary room time.	•**N/A** none listed in 2960.710, but resident rights reside in MN Rule, parts 2960.0050, entitled, Resident Rights And Basic Services and cannot be violated, including practices that constitute physical, sexual and psych abuse or neglect.

Synopsis of Scope Applicability and Purpose of Various Minnesota Statutes and Rules As Well As Arizona Policy and Federal Laws On The Use of Restrictive Aversive/Deprivation Procedures				**Website References** **M.S. 125A.0942** - https://www.revisor.mn.gov/statutes/?id=125A.0942 **M.S. 121A.58** - https://www.revisor.mn.gov/statutes/?id=121A.58 **M.S. 121A.582** - https://www.revisor.mn.gov/statutes/?id=121A.582 **Rule. 3525.0850** - https://www.revisor.mn.gov/rules/?id=3525.0850 **Rule 3525.2900-** - https://www.revisor.mn.gov/rules/?id=3525.2900			
POLICY	**PEOPLE**	**PROVIDERS**	**PURPOSE**	**POSITIVE**	**EXEMPT**	**RESTRICTIVE PERMITTED/ CONTROLLED**	**PROHIBITED**
MN Statutes, section 125A.0942 **Other Relevant and Supporting MN Statute sections and MN Rule parts include:** **MN Statutes, sections 121A.582, 121A.58, and 121A .67** **&** **MN Rules parts 3525.0850 and 3525.2900**	•Children with disabilities within special education in public schools.	•Public School – Special Education Programs.	•Establishes requirements for schools to meet in using restrictive procedures within a written IEP, behavioral intervention plan or on an emergency basis. • Requires the school to list all allowable restrictive procedures used. • Requires the school to establish a system and structure for notification, consent, monitoring and review, including post-use debriefings and an oversight committee •only trained staff can use restrictive procedures.	•School districts are encouraged to establish effective school-wide systems of positive behavior interventions and supports. •Trained school personnel use: (1) positive behavioral interventions; (2)assessing communicative intent of behaviors; (3) relationship building; (4) alternatives to restrictive procedures, & (5) de-escalation methods. •Requires documentation that positive approaches have been tried unsuccessfully.	•Removing a child from an activity to a location where the child cannot participate in or observe the activity.	•Physical holding • Seclusion (=locked room time-out) •until August 1, 2012, school districts may use prone restraints with only well-trained staff.	•Practices that constitute physical, sexual & psych abuse or neglect, •Restricting access to normative & needed goods and services, •Deny access to family and legal representation, •fully depriving sensory restrictions, •Intense aversive stimuli, •bodily pain-inducing techniques, • Prone Restraint, •Physical holding that impairs breathing, ability to communicate distress, straddles and compresses the child's body or torso, •Faradic skin shock .

***Rule 36 Variance**

Synopsis of Scope Applicability and Purpose of Various Minnesota Statutes and Rules As Well As Arizona Policy and Federal Laws On The Use of Restrictive Aversive/Deprivation Procedures				**Website References** *** Rule # 36 Variance IRTS & CS Link is listed below.**			
POLICY	**PEOPLE**	**PROVIDERS**	**PURPOSE**	**POSITIVE**	**EXEMPT**	**RESTRICTIVE PERMITTED/ CONTROLLED**	**PROHIBITED**
Variance for Intensive Residential Treatment Facilities (IRTS) and Residential Crisis Stabilization Programs (CS) Licensed Under Minnesota Rules Parts 9520.0500 to 9520.0690 (aka Rule # 36)	•Adults with Mental Illness residing in either an Intensive Residential Treatment Facility or a Residential Crisis Stabilization Program.	•Residential Treatment Facility *(governed by M.S. sections 256B.0622 & 245.472)* or a •Residential Crisis Stabilization Program *(governed by M.S. sections 256B.0624)* •Both IRTSs and CSs are Licensed Under MN Rules Parts 9520.0500 to 9520.0690 (aka Rule# 36).	•IRTS services involve consumer choice and active participation in the therapeutic or rehabilitative treatment processes for psychiatric stability, personal/emotional adjustment, developing self-sufficiency and independent living skills in various life domains or areas. •CS services are individualized mental health interventions for restoring the person to prior functioning levels**.**	•Uses well-established rehabilitative principles and effective evidence-based therapeutic treatment practices. •Comprehensive functional & diagnostic assessments. •Person-centered plans to prevent restraint & seclusion •Required post-restraint or post-seclusion debriefing. • Required non-physical de-escalation and alternative emergency interventions.	• Required non-physical de-escalation and alternative emergency interventions.	•The use of physical restraints or seclusion is only justified as a measure in response to the likelihood of physical harm to self or others, and may not be used as a planned treatment modality.	•Maltreatment as defined in the Vulnerable Adults Protection Act, •Intentional and nontherapeutic infliction of Bodily pain or injury, •Any persistent course of conduct intended to produce mental or emotional distress, • Physical restraints used as a planned treatment modality, and •Chemical or mechanical restraints.

***http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs_id_058464**

Synopsis of Scope Applicability and Purpose of Various Minnesota Statutes and Rules As Well As Arizona Policy and Federal Laws On The Use of Restrictive Aversive/Deprivation Procedures				**Website References** AZ ARTICLE 9 - http://www.azsos.gov/public_services/Title_06/6-06.htm#ARTICLE_9			
POLICY	**PEOPLE**	**PROVIDERS**	**PURPOSE**	**POSITIVE**	**EXEMPT**	**RESTRICTIVE PERMITTED/ CONTROLLED**	**PROHIBITED**
Arizona Administrative Code **Article 9:** **R6-6-901 To R6-6-910:** **Managing Inappropriate Behaviors**	•Adults and children with developmental disabilities.	All developmental disabilities programs and services operated, licensed, certified, supervised or financially supported by the Arizona Developmental Disabilities Division	•Establishes allowable and prohibited restrictive aversive and deprivation procedures to be implemented on a planned or an emergency use basis. •delineates a prescriptive process for ISPP Teams, Program Review Committees and Human Rights Committees to review, authorize and monitor restrictive aversive and deprivation procedures. •Regulates the compliant use of behavior modifying medications. •Requires ongoing training.	• Restrictive aversive and deprivation procedures are used only when less intrusive and less restrictive methods are unsuccessful or inappropriate in order to prevent harm to self, others or severe property damage.	•None Mentioned. •All training & habilitation programs as defined in A.R.S. § 36-551(18), as well as, all interventions included in Article 9: (R6-6-901 - R6-6-910) shall be addressed in the client's ISPP.	•Techniques that use force. • Response-Cost procedures. •Protective devices to prevent injury as a result of self-injurious behavior. •Use of physician or psychiatrist prescribed behavior-modifying medications compliant with ARTICLE 9: R6-6-902 and R6-6-909. •Least intrusive and least restrictive Emergency us of physical management techniques to prevent harm to self, others or severe property damage.	•physical, sexual & psych abuse or neglect, •Physical restraints and mechanical restraints used as negative consequences to behavior. •seclusion or locked time-out rooms. •overcorrection. •noxious stimuli. •Unauthorized behavioral treatment plans outside of the ISPP Team, Program Review Committee and Human Rights Committee approvals. Use of behavior-modifying medications non-compliant with Article 9: R6-6-902 and R6-6-909.

Synopsis of Scope Applicability and Purpose of Various Minnesota Statutes and Rules As Well As Arizona Policy and Federal Laws On The Use of Restrictive Aversive/Deprivation Procedures				**Website References** **42 CFR Part 482.13(e) & (f) -** http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol5/pdf/CFR-2010-title42-vol5-sec482-13.pdf **144.651, Subd. 31 & 33** - https://www.revisor.mn.gov/statutes/?id=144.651 **Rule, part 4658.0220 -** https://www.revisor.mn.gov/rules/?id=4658.0220 **Rule, part 4658.0300 -** https://www.revisor.mn.gov/rules/?id=4658.0300 **Rule, part 4658.0350 -** https://www.revisor.mn.gov/rules/?id=4658.0350				
POLICY	**PEOPLE**	**PROVIDERS**	**PURPOSE**	**POSITIVE**	**EXEMPT**	**RESTRICTIVE PERMITTED/ CONTROLLED**	**PROHIBITED**
42 CFR Part 482.13(e) & (f) **Other Relevant and Supporting MN Statute sections and MN Rule parts include:** **MN Statutes, sections 144.651, Subd. 31 & 33 & MN Rules parts 4658.0220, 4658.0300 and 4658.0350.**	•Patients or Residents of Hospitals and Health Care Facilities.	•Hospitals and Health Care Facilities.	•Establishes minimal federal regulatory standards and required protocols for the authorization, implementation, ongoing monitoring, periodic assessment (including face-to-face) reviews, reporting and renewals or continuation of restrictive restraint and seclusion procedures. •Establishes staff training requirements.	• Asserts restraint or seclusion may only be used when nonphysical intervention alternatives or less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.	•A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets. •Physical or mechanical holding of a patient for the purpose of medical procedures. •Devises that protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm.	•Allows for: - manual restraint, -Mechanical restraint -drug or med restraint -physical escorting -in accordance with a written plan of care prescribed order and state laws that are more stringent. •Restraint or seclusion must be the least restrictive intervention and discontinued at the earliest possible time.	•Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN). •Restraint or seclusion, must not be imposed as a means of coercion, discipline, punishment, convenience, or retaliation by staff.

Minnesota Department of **Human Services**

Disability Services Division

Comparison of Relevant Definitions In Various Minnesota Statutes, Rules and the Settlement Agreement As Well As Arizona Policy and Federal Laws On The Use of Restrictive Aversive/Deprivation Procedures

TERM: AVERSIVE	
POLICY	**DEFINITIONS**
Rule # 40 Minnesota Rules, parts 9525.2710 and	**A.)** "**Aversive stimulus"** means an object, event, or situation that is presented immediately following a target behavior in an attempt to suppress that behavior. Typically, an aversive stimulus is unpleasant and penalizes or confines. **B.) "Aversive procedure"** means the planned application of an aversive stimulus (1) contingent upon the occurrence of a behavior identified in the individual program plan for reduction or elimination; or (2) in an emergency situation.
Minnesota Rules, parts 2960.0020 & 2960.3010	**"Aversive procedure"** has the meaning given in Rule # 40 above.

TERMS: CONTROLLED//RESTRICTIVE	
POLICY	**DEFINITIONS**
Rule # 40 Minnesota Rules, parts 9525.2710	**"Controlled procedure"** means an aversive or deprivation procedure that is permitted by parts 9525.2700 to 9525.2810 and is implemented under the standards established by those parts.
Minnesota Statutes, section 245.8261	**"Restrictive procedures"** means application of an action, force, or condition that controls, constrains, or suppresses the action, behavior, intention, bodily placement, or bodily location of a child in a manner that is involuntary, unintended by that child, depriving, or aversive to that child.
Minnesota Rules, parts 2960.0020 &2960.3010	**"Restrictive procedure"** means a procedure used by the license holder to limit the movement of a resident, including disciplinary room time, mechanical restraint, physical escort, physical holding, and seclusion.
42 CFR Part 482.13(e)(1)	**"Restrictive Interventions"** limits an individual's movement, access to others, access to locations, access to available activities, restricts a person's rights, and uses aversive techniques (e.g., restraint, seclusion, etc.) to modify behavior.

TERM: DEPRIVATION	
POLICY	**DEFINITIONS**
Rule # 40 Minnesota Rules, parts 9525.2710	**"Deprivation procedure"** means the removal of a positive reinforcer following a response resulting in, or intended to result in, a decrease in the frequency, duration, or intensity of that response. Often times the positive reinforcer available is goods, services, or activities to which the person is normally entitled. The removal is often in the form of a delay or postponement of the positive reinforcer.
Minnesota Rules, parts 2960.0020 & 2960.3010	**"Deprivation procedure"** has the meaning given in Rule # 40 above.

TERM: DISCIPLINE	
POLICY	**DEFINITIONS**
Minnesota Rules, parts 2960.0020 & 2960.3010	**"Discipline"** means the use of reasonable, age-appropriate consequences designed to modify and correct behavior according to a rule or system of rules governing conduct.
Minnesota Rules, parts 4658.0300	"**Discipline"** means any action taken by the nursing home for the purpose of punishing or penalizing a resident
Minnesota Rules, parts 9515.3090	**"Disciplinary restrictions"** means withholding or limiting privileges otherwise available to a person in treatment as a consequence of the person's violating rules of behavior.

TERM: EMERGENCY	
POLICY	**DEFINITIONS**
Settlement	**"Emergency"** means situations when the client's conduct poses an imminent risk of physical harm to self or others, and less restrictive strategies would not achieve safety. Client refusal to receive/participate in treatment shall not constitute and emergency.
Rule # 40 Minnesota Rules, parts 9525.2710	**"Emergency use" means using a controlled procedure** without first meeting the requirements in parts 9525.2750, 9525.2760, and 9525.2780 **when it can be documented** under part 9525.2770 **that immediate intervention is necessary to protect a person or other individuals from physical injury or to prevent severe property damage which is an immediate threat to the physical safety of the person or others.**
Minnesota Statutes, section 125A.0941	**"Emergency"** means a situation where immediate intervention is needed to protect a child or other individual from physical injury or to prevent serious property damage.
Minnesota Rules, parts 4658.0300	**"Emergency measures"** means the immediate action necessary to alleviate an unexpected situation or sudden occurrence of a serious and urgent nature**.**
42 CFR Part 482.13(e)(1)	**"Emergency measure"** means the use of the least restrictive procedures and for the briefest time necessary to control severely aggressive or destructive behaviors that place the individual or others in imminent danger, when those behaviors reasonably could not have been anticipated, and only as they are necessary within the context of positive behavioral programming.
AZ Code, Article # 9 and Chapter 1600	**"Emergency Measures"** are defined as the use of physical management techniques or psychotropic medications in an emergency to manage a sudden, intense or out-of-control behavior.

TERM: SECLUSION	
POLICY	**DEFINITIONS**
Settlement and Rule # 40 Minnesota Rules, parts 9525.2710	**"Seclusion"** means the placement of a person alone in a room from which egress is: A.) non-contingent on the person's behavior; or B.) prohibited by a mechanism such as a lock or by a device or object positioned to hold the door closed or otherwise prevent the person from leaving the room.
Minnesota Statutes, section 245.8261	**"Seclusion"** involves the confining of a child alone in a room from which egress is beyond the child's control or prohibited by a mechanism such as a lock or by a device or object positioned to hold the door closed or otherwise prevent the child from leaving the room. The room used for seclusion must be well-lighted, well-ventilated, clean, have an observation window that allows staff to directly monitor the child in sedusion, fixtures that are tamperproof, electrical switches located immediately outside the door, and doors that open out and are unlocked or locked with keyless locks that have immediate release mechanisms.
Minnesota Rules, parts 2960.0020 & 2960.3010	**"Seclusion"** means confining a person in a locked room.
Minnesota Statutes, section 125A.0941	**"Seclusion"** means confining a child alone in a room from which egress is barred. Removing a child from an activity to a location where the child cannot participate in or observe the activity is not seclusion.
Rule # 36 Variance for IRTS & CS	**"Seclusion"** means involuntary removal into a separate room which prevents social contact with other persons.
Minnesota Rules, parts 9530.6510	**"Seclusion"** means the temporary placement of a client, without the client's consent, in an environment to prevent social contact.
42 CFR Part 482.13(e)(1)	**"Seclusion"** is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Sedusion may only be used for the management of violent or self-destructive behavior.
Minnesota Rules, parts 9515.3090	**"Emergency seclusion"** means an emergency intervention that physically separates the person in treatment from others, including placing the person in a room from which the person is not able or permitted to exit.

TERM: TIME-OUT	
POLICY	**DEFINITIONS**
Settlement	**"Time out"** means removing a client from the opportunity to gain positive reinforcement, and is employed when a client demonstrates a behavior identified in the individual program plan for reduction or elimination. Room time out means removing a client from an ongoing activity to a room (either locked or unlocked).
Rule # 40 Minnesota Rules, parts 9525.2710	**"Time out" or "time out from positive reinforcement"** means removing a person from the opportunity to gain positive reinforcement and is employed when a person demonstrates a behavior identified in the individual program plan for reduction or elimination. Return of the person to normal activities from the time out situation is contingent upon the person's demonstrating more appropriate behavior. Time out periods are usually brief, lasting only several minutes. Time out procedures governed by parts 9525.2700 to 9525.2810 are: **A.) "exclusionary time out**," which means removing a person from an ongoing activity to a location where the person cannot observe the ongoing activity; and **B.) "room time out,"** which means removing a person from an ongoing activity to an unlocked room. The person may be prevented from leaving a time out room by staff members but not by mechanical restraint or by the use of devices or objects positioned to hold the door closed.
Minnesota Statutes, section 245.8261, Subd. 3	**"Time out"** means removing a child from an activity to a location where the child cannot participate or observe the activity and includes moving or ordering a child to an unlocked room.
Minnesota Rules, parts 2960.0020 & 2960.3010	**A.) "Disciplinary room time**" means a penalty or sanction in which the resident of a Department of Corrections licensed program is placed in a room from which the resident is not permitted to exit, and which must be issued according to the facility's due process system as stated in the facility's disciplinary plan. **B.) "Time-out"** means a treatment intervention in which a caregiver trained in time-out procedures removes a resident from an ongoing activity to an unlocked room or other separate living space that is safe and where the resident remains until the precipitating behavior stops. **C.) "Time-out"** means a treatment intervention in which a caregiver trained in time-out procedures removes a child from an ongoing activity to an unlocked room or area commonly used as a living space that is safe and where the child remains until the precipitating behavior abates or stops.
42 CFR Part 482.13(e)(1)	**"Timeout"** is an intervention where the patient consents to being alone in a designated area for an agreed upon timeframe from which the patient is not physically prevented from leaving. Therefore, the patient can leave the designated area when the patient chooses.

TERMS: CHEMICAL//DRUG//MEDICATION RESTRAINTS	
POLICY	**DEFINITIONS**
Settlement	**"Chemical restraint"** means the administration of a drug or medication when it is used as a restriction to manage the client's behavior or restrict the client's freedom of movement and is not a standard treatment or dosage for the client's condition. Orders or prescriptions for the administration of medications to be used as a restriction to manage the client's behavior or restrict the client's freedom of movement shall not be written as a standing order or on an as-needed (PRN) basis.
Minnesota Rules, parts 4658.0300	**"Chemical restraints"** means any psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms.
42 CFR Part 482.13(e)(1)	A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
AZ Code, Article # 9 and Chapter 1600	**"Behavior Modifying Medications"** are drugs prescribed, administered and directed specifically toward the reduction and eventual elimination of specific behaviors, including herbal supplementation remedies due to their psychoactive and potentially behavior modifying properties. The use of psychotropic medications is prohibited if they are administered on an as-needed, or PRN basis, they are in dosages which interfere with the individual's daily living activities, or they are used in the absence of a behavior treatment plan.

TERMS: MANUAL RESTRAINTS//PHYSICAL RESTRAINTS//PHYSICAL HOLDING

POLICY	DEFINITIONS
Settlement	**"Manual restraint"** means physical intervention intended to hold a client immobile or limit a client's movement by using body contact as the only source of physical restraint. It is any manual method that restricts freedom of movement or normal access to one's body, including hand or arm holding to escort an individual over his or her resistance to being escorted. The term does not mean physical contact used to: facilitate a client's completion of a task or response when the client does not resist or the client's resistance is minimal in intensity and duration; conduct necessary medical examinations or treatments; response blocking and brief redirection used to interrupt an individual's limbs or body without holding a client or limiting his or her movement; or holding an individual, with no resistance from that individual, to calm or comfort. "**Prone Restraint"** means any restraint that places the individual in a facedown position. Prone restraint does not include brief physical holding of an individual who, during the incident of physical restraint, rolls into a prone or supine position, when staff restore the individual to a standing, sitting, or side-lying, position as soon as possible.
Rule # 40 Minnesota Rules, parts 9525.2710	**"Manual restraint"** means physical intervention intended to hold a person immobile or limit a person's movement by using body contact as the only source of physical restraint. The term does not mean physical contact used to: (1) facilitate a person's completion of a task or response when the person does not resist or the person's resistance is minimal in intensity and duration; (2) escort or carry a person to safety when the person is in danger; or (3) conduct necessary medical examinations or treatments.
Minnesota Statutes, section 245.8261, Subd. 3	**"Physical holding"** means physical intervention intended to hold a child immobile or limit a child's movement by using body contact as the only source of physical restraint. The term does not mean physical contact: (1) used to facilitate a child's response or completion of a task when the child does not resist or the child's resistance is minimal in intensity and duration; and (2) necessary to conduct a medical examination or treatment.
Minnesota Rules, parts 2960.0020 & 2960.3010	**"Physical holding"** means immobilizing or limiting a person's movement by using body contact as the only source of restraint. Physical holding does not include actions used for physical escort.
Minnesota Statutes, section 125A.0941	**"Physical holding"** means physical intervention intended to hold a child immobile or limit a child's movement and where body contact is the only source of physical restraint. The term physical holding does not mean physical contact that: (1) helps a child respond or complete a task; (2) assists a child without restricting the child's movement; (3) is needed to administer an authorized health-related service or procedure; or (4) is needed to physically escort a child when the child does not resist or the child's resistance is minimal.
Minnesota Rules, parts 4658.0300	**"Physical restraints"** means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, and wheelchair safety bars. Physical restraints also include practices which meet the definition of a restraint, such as tucking in a sheet so tightly that a resident confined to bed cannot move; bed rails; chairs that prevent rising; or placing a resident in a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails are considered a restraint if they restrict freedom of movement. If the bed rail is used solely to assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room or area do not, in and of themselves, restrict freedom of movement and should not be considered restraints.
Rule # 36 Variance for IRTS & CS	**"Restraint"** means physically limiting the free and normal movement of body and limbs.
Minnesota Rules, parts 9530.6510	**"Physical restraint"** means the restraint of a client by use of equipment to limit the movement of limbs or use of physical holds intended to limit the body of movement.

42 CFR Part 482.13(e)(1)	**"Restraint"** is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

TERM: MECHANICAL RESTRAINTS

POLICY	DEFINITIONS
Settlement	**"Mechanical restraint"** means the use of devices to limit a client's movement or hold a client immobile as an intervention precipitated by a client's behavior. The term does not apply to devices used to treat a client's medical needs to protect a client known to be at risk of injury resulting from lack of coordination or frequent loss of consciousness, or to position a client with physical disabilities in a manner specified in the client's Treatment Plan. "**Prone Restraint"** means any restraint that places the individual in a facedown position.
Rule # 40 Minnesota Rules, parts 9525.2710	**"Mechanical restraint"** means the use of devices such as mittens, straps, restraint chairs, or papoose boards to limit a person's movement or hold a person immobile as an intervention precipitated by a person's behavior. The term does not apply to mechanical restraint used to treat a person's medical needs, to protect a person known to be at risk of injury resulting from lack of coordination or frequent loss of consciousness, or to position a person with physical disabilities in a manner specified in the person's individual program plan. The term does apply to, and parts 9525.2700 to 9525.2810 do govern, mechanical restraint when it is used to prevent injury with persons who engage in behaviors, such as head-banging, gouging, or other actions resulting in tissue damage, that have caused or could cause medical problems resulting from the self-injury.
Minnesota Statutes, section 245.8261, Subd. 3	**"Mechanical restraints"** means the use of devices to limit a child's movement or hold a child immobile. The term does not mean mechanical restraints used to: (1) treat a child's medical needs; (2) protect a child known to be at risk of injury resulting from lack of coordination or frequent loss of consciousness; or (3) position a child with physical disabilities in a manner specified in the child's plan of care.
Minnesota Rules, parts 2960.0020 & 2960.3010	**"Mechanical restraint**" means the restraint of a resident by use of a restraint device to limit body movement.
Minnesota Rules, parts 4658.0300	**"Physical restraints"** means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, and wheelchair safety bars. Physical restraints also include practices which meet the definition of a restraint, such as tucking in a sheet so tightly that a resident confined to bed cannot move; bed rails; chairs that prevent rising; or placing a resident in a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails are considered a restraint if they restrict freedom of movement. If the bed rail is used solely to assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room or area do not, in and of themselves, restrict freedom of movement and should not be considered restraints.
Rule # 36 Variance for IRTS & CS	**"Restraint"** means physically limiting the free and normal movement of body and limbs.
Minnesota Rules, parts 9530.6510	**"Physical restraint"** means the restraint of a client by use of equipment to limit the movement of limbs or use of physical holds intended to limit the body of movement.
42 CFR Part 482.13(e)(1)	**"Restraint"** is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

TERM: PHYSICAL ESCORT	
POLICY	**DEFINITIONS**
Minnesota Statutes, section 245.8261	**"Physical escort"** means physical intervention or contact used as a behavior management technique to guide or carry a child to safety or away from an unsafe or potentially harmful and escalating situation.
Minnesota Rules, parts 2960.0020 & 2960.3010	**"Physical escort"** means the temporary touching or holding of a resident's hand, wrist, arm, shoulder, or back to induce a resident in need of a behavioral intervention to walk to a safe location.
42 CFR Part 482.13(e)(1)	**"Physical escort'** a light grasp to escort the patient to a desired location. If the patient can easily remove or escape the grasp, this would not be considered physical restraint. However, if the patient cannot easily remove or escape the grasp, this would be considered physical restraint and all the requirements would apply.

OTHER RELEVANT ADDITIONAL MN RULE & STATUTE DEFINITIONS	
POLICY	**DEFINITIONS**
Settlement	**"Therapeutic Intervention"** means a form of intervention which consists of early identification of potential emergencies; prevention of emergencies through verbal, non-verbal, and nonphysical methods; diversion by providing choices to client or alternate activities, environments or personal contacts. Prevention is predicated on identification of individual client needs, planning to meet those needs, and the use of specific de-escalation techniques in the client's Treatment Plan. **"Personal Safety Techniques"** means the application of external control by employees to a client only when a client causes and emergency despite the preventive therapeutic intervention strategies attempted. Physical control is based on the principle of using the least amount of force necessary to prevent injury and protect life and physical safety when positive behavior programming and other less restrictive prevention strategies have failed.
Rule # 40 Minnesota Rules, parts 9525.2710	**"Adaptive behavior"** means a behavior that increases a person's capability for functioning independently in activities of daily living. **"Target behavior"** means a behavior identified in a person's individual program plan as the object of efforts intended to reduce or eliminate the behavior. **"Baseline measurement"** means the frequency, intensity, duration, or other quantification of a behavior. The baseline measurement is determined before initiating or changing an intervention procedure to modify that behavior. **"Positive reinforcement"** means the presentation of an object, event, or situation following a behavior that increases the probability of the behavior recurring. Typically, the object, event, or situation presented is enjoyable, rewarding, or satisfying. **"Positive practice overcorrection**" means a procedure that requires a person to demonstrate or practice a behavior at a rate or for a length of time that exceeds the typical frequency or duration of that behavior. The behaviors identified for positive practice are typically appropriate adaptive behaviors or are incompatible with a behavior identified for reduction or elimination in a person's individual program plan. **"Restitutional overcorrection"** means a procedure that requires a person to clean, repair, or correct an area or situation damaged or disrupted as a result of the person's behavior to a point where the area or situation is not only restored to but exceeds its original condition.
Minnesota Statutes, section 125A.0941	**"Positive behavioral interventions and supports"** means interventions and strategies to improve the school environment and teach children the skills to behave appropriately.
Minnesota Rules, parts 4658.0300	**"Convenience"** means any action taken solely to control resident behavior or maintain a resident with a lesser amount of effort that is not in the resident's best interest.
Minnesota Rules, parts 9515.3090	**"Protective isolation"** means placing a person in treatment in a room from which the person is not able or permitted to exit as a way of defusing or containing dangerous behavior that is uncontrollable by any other means.

OTHER RELEVANT ADDITIONAL ARIZONA REGULATION DEFINITIONS	
POLICY	**DEFINITIONS**
Arizona Code Article 9: R6-6-901 To R6-6-910 & Department of Economic Security - Division of Developmental Disabilities - Policy and Procedures Manual Chapter 1600: Managing Inappropriate Behaviors	**"Inappropriate Behavior"** means to significantly interfere with, prevent or deny individual opportunities for community integration and full inclusion; to be at risk to an individual's own health and safety and/or to be at risk to the health and safety of others. **"Response-Cost"** means a procedure associated with token economies, designed to decrease inappropriate behaviors, in which reinforcers are taken away as a consequence of inappropriate behavior. **"Overcorrection"** means a group of procedures designed to reduce inappropriate behavior, and consisting of: 1.) requiring an individual to restore the environment to a state vastly improved from that which existed prior to the inappropriate behavior; or 2.) requiring an individual to repeatedly practice a behavior. **"Restitution"** is defined as the act of repaying or compensating for loss or damage. Restitution can take several forms including: a.) Payment for repair or replacement. b.) Return of property to the rightful owner. c.) Repair or replacement of damaged property through the actions of the individual responsible (i.e., the person replaces the broken window him/herself). d.) Completion of other type and amount of work that is agreed to be equivalent to the value of the damaged property (i.e., the person mows the lawn of the victim for a month after breaking the window). Restitution can be voluntarily performed by the individual, function as a consequence to behavior, serve as compensation or restoration. **"Significant Behavioral Disturbance"** is defined as any physical aggression or pattern of verbal aggression or other actions that are not typical for the individual (such as significant deterioration in personal hygiene or social withdrawal).

Definition Website References

Settlement Agreement – Attachment A Definitions
http://www.johnsoncondon.com/documents/SettlementAgreementAttachmentA.pdf

Rule # 40 Minnesota Rules, parts 9525.2710 https://www.revisor.mn.gov/rules/?id=9525.2710

Minnesota Statutes, section 245.8261 https://www.revisor.leg.state.mn.us/statutes/?id=245.8261&year=2008

Minnesota Rules, parts 2960.0020 https://www.revisor.mn.gov/rules/?id=2960.0020

Minnesota Rules, parts 2960.3010 https://www.revisor.mn.gov/rules/?id=2960.3010

Minnesota Statutes, section 125A.0941 https://www.revisor.mn.gov/statutes/?id=125A.0941

Minnesota Rules, parts 4658.0300 https://www.revisor.mn.gov/rules/?id=4658.0300

42 CFR Part 482.13(e)(1) http://law.justia.com/cfr/title42/42-3.0.1.5.21.2.199.3.html

Rule # 36 Variance for IRTS & CS
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs_id_058464

Minnesota Rules, parts 9530.6510 https://www.revisor.mn.gov/rules/?id=9530.6510

Minnesota Rules, parts 9515.3090 https://www.revisor.mn.gov/rules/?id=9515.3090

Department of Economic Security-Division of Developmental Disabilities Policy and Procedures Manual Chapter 1600: Managing Inappropriate Behaviors https://www.azdes.gov/uploadedFiles/Developmental.../1600.pdf