(9) "Consent" means concurrence by a client or his legally responsible person following receipt of information from the qualified professional who will administer the proposed treatment or procedure. Informed consent implies that the client or his legally responsible person was provided with information concerning proposed treatment, including both benefits and risks, in order to make an educated decision with regard to such treatment.

(10) "Dangerous articles or substances" mean, but are not limited to, any weapon or potential weapon, heavy blunt object, sharp objects, potentially harmful chemicals, or drugs of any sort, including alcohol.

(11) "Division Director" means the Director of the Division or his designee.

(12) "Emergency" means a situation in a state facility in which a client is in imminent danger of causing abuse or injury to self or others, or when substantial property damage is occurring as a result of unexpected and severe forms of inappropriate behavior, and rapid intervention by the staff is needed. [See Subparagraph (b)(25) of this Rule for definition of medical emergency].

(13) "Emergency surgery" means an operation or surgery performed in a medical emergency [as defined in Subparagraph (b)(25) of this Rule] where informed consent cannot be obtained from an authorized person, as specified in G.S. 90-21.13, because the delay would seriously worsen the physical condition or endanger the life of the client.

(14) "Exclusionary time-out" means the removal of a client to a separate area or room from which exit is not barred for the purpose of modifying behavior.

(15) "Exploitation" means the use of a client or her/his resources including borrowing, taking or using personal property with or without her/his permission for another person's profit, business or advantage.

(16) "Forensic Division" means the unit at Dorothea Dix Hospital which serves clients who are:

(E) admitted for the purpose of evaluation for capacity to proceed to trial;

(F) found not guilty by reason of insanity;

(G) determined incapable of proceeding to trial; or

(H) deemed to require a more secure environment to protect the health, safety and welfare of clients, staff and the general public.

(17) "Grievance" means a verbal or written complaint by or on behalf of a client concerning a situation within the jurisdiction of the state facility. A grievance does not include complaints that can be resolved without delay by staff present. A complaint that is not resolved shall be filed and processed in accordance with the requirements of 10A NCAC 28B .0203.

(18) "Human Rights Department" means a Department, appointed by the Secretary, to act in a capacity regarding the protection of client rights.

(19) "Independent psychiatric consultant" means a licensed psychiatrist not on the staff of the state facility in which the client is being treated. The psychiatrist may be in private practice, or be employed by another state facility, or be employed by a facility other than a state facility as defined in G.S. 122C-3(14).

(20) "Interpreter services" means specialized communication services provided for the hearing impaired by interpreters certified by the National Registry of Interpreters for the Deaf or the National Association of the Deaf.

(21) "Involuntary client" means a person admitted to any regional psychiatric hospital or alcoholic rehabilitation center under the provisions of Article 5, Parts 7, 8 or 9 of G.S. 122C and includes but it is not limited to clients detained pending a district court hearing and clients involuntarily committed after a district court hearing. This term shall also include individuals who are defendants in criminal actions and are being evaluated in a state facility for mental responsibility or mental competency as a Phase of such criminal proceedings as specified in G.S. 15A-1002 unless a valid order providing otherwise is issued from a court of competent jurisdiction and the civil commitment of defendants found not guilty by reason of insanity as specified in G.S. 15A-1321.

(22) "Isolation time-out" means the removal of a client to a separate room from which exit is barred but which is not locked and where there is continuous supervision by staff for the purpose of modifying behavior.

(23) "Licensed professional counselor (LPC)" means a counselor who is licensed as such by the North Carolina Board of Licensed Professional Counselors.

(24) "Major physical injury" means damage caused to the body resulting in profuse bleeding or contusion of tissues; fracture of a bone; damage to internal organs; loss of consciousness; loss of normal neurological function (inability to move or coordinate movement); or any other painful condition caused by such injury.

(25) "Medical emergency" means a situation where the client is unconscious, ill, or injured, and the reasonably apparent circumstances require prompt decisions and

actions in medical or other health care, and the necessity of immediate health care treatment is so reasonably apparent that any delay in the rendering of the treatment would seriously worsen the physical condition or endanger the life of the client.

(1) "Minimal risk research" means that the risks of harm anticipated in the proposed research are not greater, considering probability and magnitude, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

(2) "Minor client" means a person under 18 years of age who has not been married or who has not been emaEBPIpated by a decree issued by a court of competent jurisdiction or is not a member of the armed forces.

(3) "Neglect" means the failure to provide care or services necessary to maintain the mental and physical health of the client.

(4) "Normalization" means the priEBPIple of helping the client to obtain an existence as close to normal as possible, taking into consideration the client's disabilities and potential, by making available to him patterns and conditions of everyday life that are as close as possible to the norms and patterns of the mainstream of society.

(5) "Paraprofessional" within the mh/dd/sa system of care means an individual who, with the exception of staff providing respite services or personal care services, has a GED or high school diploma; or no GED or high school diploma, employed prior to November 1, 2001 to provide a mh/dd/sa service. Upon hiring, an individualized supervision plan shall be developed and supervision shall be provided by a qualified professional or associate professional with the population served.

(6) "Person standing in loco parentis" means one who has put himself in the place of a lawful parent by assuming the rights and obligations of a parent without formal adoption.

(7) "Physical Restraint" means the application or use of any manual method of restraint that restricts freedom of movement, or the application or use of any physical or mechanical device that restricts freedom of movement or normal access to one's body, including material or equipment attached or adjacent to the client's body that he or she cannot easily remove. Holding a client in a therapeutic hold or any other manner that restricts his or her movement constitutes manual restraint for that client. Mechanical devices may restrain a client to a bed or chair, or may be used as ambulatory restraints. Examples of mechanical devices include cuffs, ankle straps, sheets or restraining shirts, arm splints, mittens and helmets. Excluded from this definition of physical restraint are physical guidance, gentle physical prompting techniques, escorting and therapeutic holds used solely for the purpose of escorting a client who is walking, soft ties used solely to prevent a medically ill client from removing intravenous tubes, indwelling catheters, cardiac monitor electrodes or similar medical devices, and prosthetic devices or assistive technology which are designed and used to increase client adaptive skills. Escorting means the temporary touching or holding of the hand, wrist, arm, shoulder or back for the purpose of inducing a client to walk to a safe location.

(8) "Protective devices" means an intervention which provides support for weak and feeble clients or enhances the safety of behaviorally disordered clients. Such devices may include posey vests, geri-chairs or table top chairs to provide support and safety for clients with physical handicaps; devices such as helmets and mittens for self-injurious

behaviors; or devices such as soft ties used to prevent medically ill clients from removing intravenous tubes, indwelling catheters, cardiac monitor electrodes or similar medical devices. As provided in Rule .0207 of Subchapter 28D, the use of a protective device for behavioral control shall comply with the requirements specified in Rule .0203 of Subchapter 28D.

(9) "Psychotropic medication" means medication with the primary function of treating mental illness, personality or behavior disorders. It includes, but is not limited to, antipsychotics, antidepressants, antianxiety agents and mood stabilizers.

(10) "Qualified professional" means, within the mh/dd/sas system of care, an individual who is:

(A) an individual who holds a license, provisional license, certificate, registration or permit

issued by the governing board regulating a human service profession, except a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing who also has four years of full-time accumulated experience in mh/dd/sa with the population served; or a graduate of a college or university with a Masters degree in a human service field and has one year of full-time, post-graduate degree accumulated mh/dd/sa experience with the population served, or a substance abuse professional who has one-year of full-time, postgraduate degree accumulated supervised experience in alcoholism and drug abuse counseling; or

(I) a graduate of a college or university with a bachelor's degree in a human service field and has two years of full-time, post-bachelor's degree accumulated mh/dd/sa experience with the population served, or a substance abuse professional

who has two years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling; or

(J) a graduate of a college or university with a bachelor's degree in a field other than human services and has four years of full-time, post-bachelor's degree accumulated mh/dd/sa experience with the population served, or a substance abuse professional who has four years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling.

(36) "Regional alcohol and drug abuse treatment center" means a state facility for substance abusers as specified in G.S. 122C-181(a)(3).

(37) "Regional mental retardation center" means a state facility for the mentally retarded as specified in G.S. 122C-181(a)(2).

(38) "Regional psychiatric hospital" means a state facility for the mentally ill as specified in G.S. 122C-181(a)(1).

(39) "Representative payee" means the person, group, or facility designated by a funding source, such as Supplemental Security Income (SSI), to receive and handle funds according to the guidelines of the source on behalf of a client.

(40) "Research" means inquiry involving a trial or special observation made under conditions determined by the investigator to confirm or disprove an hypothesis or to explicate some priEBPIple or effect.

(41) "Respite client" means a client admitted to a mental retardation center for a short-term period, normally not to exceed 30 days. The primary purpose of such admission is to provide a temporary interval of rest or relief for the client's regular caretaker.

(42) "Responsible professional" shall have the meaning as specified in G.S. 122C-3 except the "responsible professional" shall also be a qualified professional as defined in Subparagraph (b)(35) of this Rule.

(43) "Seclusion" means isolating a client in a separate locked room for the purpose of controlling a client's behavior. In the Forensic Service, Pretrial Evaluation Unit and the Forensic Treatment Program Maximum Security Ward in the Spruill Building at Dorothea Dix Hospital, the use of locked rooms is not considered seclusion for clients with criminal charges who are:

(K) undergoing pretrial evaluations ordered by a criminal court;

(L) in treatment for restoration of capacity to proceed;

(M) in treatment to reduce violence risk; or

(N) considered to be an escape risk.

(44) "State Facility Director" means the chief administrative officer or manager of a state facility or his designee.

(45) "Strike" means, but is not limited to, hitting, kicking, slapping or beating whether done with a Phase of one's body or with an object.

(46) "Timeout" means the removal of a client from other clients to another space within the same activity area for the purpose of modifying behavior.

(47) "Treatment" means the act, method, or manner of habilitating or rehabilitating, caring for or managing a client's physical or mental problems.

(48) "Treatment plan" means a written individual plan of treatment or habilitation for each client to be undertaken by the treatment team and includes any documentation of restriction of client's rights.

(49) "Treatment team" means an interdisciplinary group of qualified professionals sufficient in number and variety by discipline to adequately assess and address the identified needs of the client.

(50) "Unit" means an integral component of a state facility distinctly established for the delivery of one or more elements of service to which specific staff and space are assigned, and for which responsibility has been assigned to a director, supervisor, administrator, or manager.

(51) "Voluntary client" means a person admitted to a state facility under the provisions of Article 5, Parts 2, 3, 4 or 5 of G.S. 122C.

History Note: Authority G.S. 122C-3; 122C-4; 122C-51; 122C-53(f); 143B-147;
Eff. October 1, 1984;
Amended Eff. June 1, 1990; April 1, 1990; July 1, 1989;
Temporary Amendment Eff. January 1, 1998;
Amended Eff. April 1, 1999;
Temporary Amendment Eff. January 1, 2001;
Temporary Amendment Expired October 13, 2001;
Temporary Amendment Eff. November 1, 2001;
Amended Eff. April 1, 2003.

SECTION .0600 - AREA AUTHORITY OR COUNTY PROGRAM MONITORING OF FACILITIES AND SERVICES

10A NCAC 27G .0601 SCOPE

(a) This Section governs Local Management Entity (LME) monitoring of the provision of public services in the LME's catchment area.

(b) The LME shall monitor the provision of public services in the LME's catchment area.

(c) The LME shall develop and implement written policies governing monitoring of the provision of public services that include:

(1) receiving, reviewing and responding to level II and level III iEBPIdent reports as set forth in Rules .0603, .0604, and .0605 of this Section;

(2) receiving and responding to complaints concerning the provision of public services, as set forth in Rule .0606 of this Section;

(3) conducting local monitoring of Category A and B providers of public services as set forth in Rule .0608 of this Section; and

(4) analyzing and reporting trends in the information identified in Subparagraphs (c)(1) through (c)(3) of this Rule, as set forth in Rule .0608 of this Section.

(d) An LME or provider of public services shall exchange information, including confidential information, when necessary to coordinate and carry out the monitoring functions as set forth in this Section. Sharing of information shal conform to 42 CFR, Phase 2 for persons receiving Substance Abuse Services. The exchange of information shall apply as follows:

(5) an LME to another LME;

(6) an LME to a provider of public services;

(7) a provider of public services to an LME;

(8) a provider of public services to another provider of public services;

(9) a provider of public services to the Department;

(10) an LME to the Department;

(11) the Department to an LME; and

(12) the Department to a provider of public services.

History Note: Authority G.S. 122C-112.1; 143B-139.1;

Temporary Adoption Eff. July 1, 2003;

Eff. July 1, 2004;

Amended Eff. August 1, 2009.

10A NCAC 28D .0209 TRAINING: EMPHASIS ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS

(a) Facilities shall implement policies and practices that emphasize the use of alternatives to seclusion, physical restraint and isolation time-out.

(b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating

an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others, or to property is prevented.

(c) Provider ageEBPIes shall establish training based on state competeEBPIes, monitor for internal compliance and demonstrate they acted on data gathered.

(d) The training shall be competency based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.

(e) Formal refresher training shall be completed at least annually by each service provider.

(f) Content of the training that the service provider plans to use shall be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.

(g) Staff shall demonstrate competence in the following Base areas:

(1) knowledge and understanding of the people being served;

(2) recognizing and interpreting human behavior;

(3) recognizing the effect of internal and external stressors that may affect people with disabilities;

(4) strategies for building positive relationships with people with disabilities;

(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;

(6) recognizing the importance, and assisting people with disabilities in making decisions about their life;

(7) skills in assessing individual risk for escalating behavior;

(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and

(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).

(h) Service providers shall maintain documentation of initial and refresher training for at least three years.

(1) Documentation shall include:

(A) who participated in the training and the outcomes (pass/fail);

(B) when and where they attended; and

(C) Trainer's name.

(2) The Division of MH/DD/SAS may request and review this documentation at any time.

(i) Trainer Qualifications and Training Requirements:

(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for seclusion, physical restraint and isolation time-out.

(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an Trainer training program.

(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.

(4) The content of the Trainer training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.

(5) Acceptable Trainer training programs shall include but not be limited to presentation of:

(D) understanding the adult learner;

(E) methods for teaching content of the course;

(F) methods for evaluating trainee performance; and

(G) documentation procedures.

(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for physical restraint, seclusion and isolation time-out at least one time, with a positive review by the coach.

(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for seclusion, physical restraint and isolation time-out at least once annually.

(8) Trainers shall complete a refresher Trainer training at least every two years.

(j) Service providers shall maintain documentation of initial and refresher Trainer training for at least three years.

(1) Documentation shall include:

(H) who participated in the training and the outcomes (pass/fail);

(I) when and where attended; and

(J) Trainer's name; and

(2) The Division of MH/DD/SAS may request and review this documentation at any time.

(k) Qualifications of Coaches:

(10) Coaches shall meet all preparation requirements as a trainer.

(11) Coaches shall teach at least three times the course which is being coached.

(12) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.

(l) Documentation shall be the same preparation as for trainers.

History Note: Authority G.S 143B-147;

Temporary Adoption Eff. February 1, 2001;

Temporary Adoption Expired October 13, 2001;

Amended Eff. April 1, 2003

10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS

(a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.

(b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by

successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented.

(c) Provider ageEBPIes shall establish training based on state competeEBPIes, monitor for internal compliance and demonstrate they acted on data gathered.

(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.

(e) Formal refresher training must be completed by each service provider periodically (minimum annually).

(f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.

(g) Staff shall demonstrate competence in the following Base areas:

(1) knowledge and understanding of the people being served;

(2) recognizing and interpreting human behavior;

(3) recognizing the effect of internal and external stressors that may affect people with disabilities;

(4) strategies for building positive relationships with persons with disabilities;

(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;

(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;

(7) skills in assessing individual risk for escalating behavior;

(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and

(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).

(h) Service providers shall maintain documentation of initial and refresher training for at least three years.

(1) Documentation shall include:

(A) who participated in the training and the outcomes (pass/fail);

(B) when and where they attended; and

(C) Trainer's name;

(2) The Division of MH/DD/SAS may review/request this documentation at any time.

(i) Trainer Qualifications and Training Requirements:

(10) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.

(11) Trainers shall demonstrate competence by scoring a passing grade on testing in an Trainer training program.

(12) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.

(13) The content of the Trainer training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.

(14) Acceptable Trainer training programs shall include but are not limited to presentation of:

(D) understanding the adult learner;

(E) methods for teaching content of the course;

(F) methods for evaluating trainee performance; and

(G) documentation procedures.

(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.

(15) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.

(16) Trainers shall complete a refresher Trainer training at least every two years.

(j) Service providers shall maintain documentation of initial and refresher Trainer training for at least three years.

(1) Documentation shall include:

(H) who participated in the training and the outcomes (pass/fail);

(I) when and where attended; and

(J) Trainer's name.

(2) The Division of MH/DD/SAS may request and review this documentation any time.

(k) Qualifications of Coaches:

(17) Coaches shall meet all preparation requirements as a trainer.

(18) Coaches shall teach at least three times the course which is being coached.

(19) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.

(l) Documentation shall be the same preparation as for trainers.

History Note: Authority G.S. 143B-147;

Temporary Adoption Eff. February 1, 2001;

Temporary Adoption Expired October 13, 2001;

Eff. April 1, 2003

§ 122C-115.4. Functions of local management entities.

(a) Local management entities are responsible for the management and oversight of the

public system of mental health, developmental disabilities, and substance abuse services at the community level. An LME shall plan, develop, implement, and monitor services within a specified geographic area to ensure expected outcomes for consumers within available resources.

(b) The primary functions of an LME are designated in this subsection and shall not be conducted by any other entity unless an LME voluntarily enters into a contract with that entity under subsection (c) of this section. The primary functions include all of the following:

(1) Access for all citizens to the Base services and administrative functions described in G.S. 122C-2. In particular, this shall include the implementation of a 24-hour a day, seven-day a week screening, triage, and referral process and a uniform portal of entry into care.

(2) Provider monitoring, technical assistance, capacity development, and quality control. If at anytime the LME has reasonable cause to believe a violation of licensure rules has occurred, the LME shall make a referral to the Division of Health Service Regulation. If at anytime the LME has reasonable cause to believe the abuse, neglect, or exploitation of a client has occurred, the LME shall make a referral to the local Department of Social Services, Child Protective Services Program, or Adult Protective Services Program.

(3) Utilization management, utilization review, and determination of the appropriate level and intensity of services. An LME may participate in the development of person centered plans for any consumer and shall monitor the implementation of person centered plans. An LME shall review and approve person centered plans for consumers who receive State-funded services and shall conduct concurrent reviews of person centered plans for consumers in the LME's catchment area who receive Medicaid funded services.

(4) Authorization of the utilization of State psychiatric hospitals and other State facilities. Authorization of eligibility determination requests for recipients under a CAP-MR/DD waiver.

(5) Care coordination and quality management. This function involves individual client care decisions at critical treatment junctures to assure clients' care is coordinated, received when needed, likely to produce good outcomes, and is neither too little nor too much service to achieve the desired results. Care coordination is sometimes referred to as "care management." Care coordination shall be provided by clinically trained professionals with the authority and skills necessary to determine appropriate diagnosis and treatment, approve treatment and service plans, when necessary to link clients to higher levels of care quickly and efficiently, to facilitate the resolution of disagreements between providers and clinicians, and to consult with providers, clinicians, case managers, and utilization reviewers. Care coordination activities for high-risk/high-cost consumers or consumers at a critical treatment juncture include the following:

a. Assisting with the development of a single care plan for individual clients, including participating in child and family teams around the development of plans for children and adolescents.

b. Addressing difficult situations for clients or providers.

c. Consulting with providers regarding difficult or unusual care situations.

c. Ensuring that consumers are linked to primary care providers to address the consumer's physical health needs.

d. Coordinating client transitions from one service to another.

e. Conducting customer service interventions.

f. Assuring clients are given additional, fewer, or different services as client needs increase, lessen, or change.

g. Interfacing with utilization reviewers and case managers.

h. Providing leadership on the development and use of communication protocols.

i. Participating in the development of discharge plans for consumers being discharged from a State facility or other inpatient setting who have not been previously served in the community.

(6) Community collaboration and consumer affairs including a process to protect consumer rights, an appeals process, and support of an effective consumer and family advisory Department.

(6) Financial management and accountability for the use of State and local funds and information management for the delivery of publicly funded services.

(7) Each LME shall develop a waiting list of persons with intellectual or developmental disabilities that are waiting for specific services. The LME shall develop the list in accordance with rules adopted by the Secretary to ensure that waiting list data are collected consistently across LMEs. Each LME shall report this data annually to the Department. The data collected should include numbers of persons who are:

j. Waiting for residential services.

k. Potentially eligible for CAP-MRDD.

(14) Each LME to have at least one trained care coordination person on staff to serve as the point of contact for TRICARE, the North Carolina National Guard's Integrated Behavioral Health System, the Army Reserve Department of Psychological Health, the United States Department of Veterans Affairs, the Division of Adult Correction, and related organizations to ensure that members of the active and reserve components of the Armed Forces of the United States, veterans, and their family members have access to State-funded services when they are not eligible for federally funded mental health or substance abuse services.

(15) LME staff members who provide screening, triage, or referral services to receive training to enhance the services provided to members of the active or reserve components of the Armed Forces of the United States, veterans, and their families. The training required by this subdivision shall include training on at least all of the following:

m. The number of persons who serve or who have served in the active or reserve components of the Armed Forces of the United States in the LME's catchment area.

n. The types of mental health and substance abuse disorders that these service personnel and their families may have experienced, including traumatic brain injury, posttraumatic stress disorder, depression, substance use disorders, potential suicide risks, military sexual trauma, and domestic violence.

Appropriate resources to which these service personnel and their families may be referred as needed. (2006-142, s. 4(d); 2007-323, ss. 10.49(l), (hh); 2007-484, ss. 18, 43.7(a)-(c); 2007-504, s. 1.2; 2008-107, s. 10.15(cc); 2009-186, s. 1; 2009-189, s. 1; 2011-145, s. 19.1(h); 2011-185, s. 6; 2011-291, s. 2.45; 2012-66, s. 2; 2012-83, s. 43.)

Evidenced Based Protective Interventions

EBPI

Participant Workbook

Prevent and Alternatives

July 2017

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THIS TRAINING

The goal of this training program is to teach skills that help prevent the use of restraints, seclusion or isolation time out. You are the key to reaching that goal. It is important that you and everyone caring for, treating and supporting people with disabilities, know how to communicate to create positive relationships, to treat others with respect and to handle yourselves when the going gets tough.

In the course of your work with people, you will be asked to be many things —teacher, coach, nurse, sounding board, role model. It is challenging work, but there are many rewards. The main one is seeing the people you are working with improve the quality of their lives. Hopefully, the attitudes and skills you learn in this training will help bring that about.

PART I UNIT ONE
UNDERSTANDING CAUSES OF BEHAVIOR IN PEOPLE

Key Points

1. Emotional and learned factors such as smiling, scowling, displaying anger or yelling can influence how staff behaves and can trigger negative or positive dynamics of the interactions between them and the individual's being served in a program
2. Psychological factors such as delusions, paranoia, personality disorders or cognitive impairment can influence the behavior of the individuals served. Emotional factors such as fear and anger can influence aggressive behaviors in the individuals served
3. Environmental factors such as excessive noise, hot or cold weather, or time of day can cause negative behaviors. Social exposure to negative behaviors such as aggression can influence aggressive behaviors in individuals
4. Personality traits, learned behavior and belief systems can influence and trigger certain behaviors in human beings
5. Health issues, stress, losses, fears and lack of control over what goes on in life can lead to feelings of sadness, anger and hostility
6. How you think about the behaviors and habits of others can influence how you think about and respond to them
7. We can learn more about the people we serve by doing things with them, reading their record and talking to others that know the person like family, friends and staff that work with the individual

Training on Alternatives to Restrictive Intervention

HOW YOUR BEHAVIOR AFFECTS OTHERS

Your behavior affects other people. Think about what happens when you smile at someone. Usually the other person smiles back. If you say, "How are you?" to someone, they will probably say, "Fine." (They may be feeling lousy, but they will usually say "Fine!"). The same can be said about how staff behavior affects the individuals they serve. For example if you have had a bad day so far and are feeling upset or angry at something that had happened at home and come to work displaying behaviors associated with the bad feeling; the individuals that you serve will be affected by your behavior. If you come in with a scowl on your face then and barking directions it can and will trigger negative and unwanted behaviors from the people you serve. On the other hand when you walk through the door with a smile on your face and using effective communications and active listening techniques the people you serve will respond accordingly.

Psychological or emotional factors

Individuals suffering from delusions, especially paranoid, can feel they are being threatened and this can lead to defensive and challenging responses on their part. People with personality disorders may have difficulty foreseeing the consequences on others of their actions and may become acutely distressed. Fear is powerful in provoking difficult or aggressive behaviors. Anger can arise at a time of threat, as part of bereavement, or if needs are not being met.

Environmental or social factors

Factors relating to an individual's surroundings (e.g. excessive noise) can be provocative particularly if they are prolonged or persistent and may also interfere with the individual's rest and sleep. People with cognitive impairment often find care surroundings overwhelming and over-stimulating and may not keep up with the speed or volume of information or activity they are exposed to. Individuals that are exposed to yelling may yell to get their point across. Individuals that are exposed to physical punishment may tend to become physically aggressive when confronted with another person that is non-compliant to behave in a way they want

How a Person's Disability May Affect Them

When we look at what influences human beings behavior we must look at all people. That means we attempt to look at what causes behavior in both us as staff as well as the individuals we serve. At the same time we must realize that the various factors that cause behavior are the same for all human beings. There are many different reasons and factors that influence human behavior. These factors include the following: Behavior influenced by events; Belief systems or thoughts; Emotions or what we are feeling; what and how we learn; the present or current condition of our health; Environmental and organizational factors. These are the same factors that influence the behavior of individuals that are served in a program as well as staff themselves.

Models of human behavior look at both hereditary factors and social environmental factors when they look to explain what influences human behavior. In other words these factors consider the age old debate of nature versus nurture which is one of the oldest arguments in the history of psychology. Each of these sides have good points that it's

really hard to decide whether a person's development is predisposed in his DNA, or a majority of it is influenced by this life experiences and his social environment. As of now, we know that both nature and nurture play important roles in human development, but we have not known yet whether we are developed majorly because of nature or due to nurture.

Let's look at several empirically or evidenced based models that explain human behavior from both points of view:

The Genetics Approach: the personality traits of a human being are largely determined by inherited biological factors and that there is a significant inherited component to personality. In this approach it is argued that both heredity and environment influence personality. However it is our genes that form a large portion of our personality, which gives us our basic physical statute, temperament and level of intelligence. These raw genetic factors are shaped as we develop by learning and experience. Although we are all unique there are still some universal common traits however individual traits or personal disposition best describe our nature more accurately.

The Behavioral Approach: this approach in its strict version does not consider genetics in its calculation but infers that behavior is shaped more by learning and external factors than genetics. In this approach behaviors are shaped by what people learn in childhood but can be modified and new behavior patterns can be acquired at any age. In this approach the behavior of a person is reinforced by environmental factors that can be manipulated to alter behavior. Behavior modification programs are used to shape behavior and include functional analysis which is 1) documenting the

frequency of an identified behavior; 2) documenting the situation or event and; 3) reinforcement associated with the behavior.

When working with the behavioral approach and documenting a baseline behavior of a consumer it is always remember to document;

- Antecedent (A);
- Behavior (B) and
- Consequence (C).

It is important that documentation include the situation or event (Antecedent) that had previously occurred that triggered the behavior (B). Remember that base lining can be used for both appropriate behaviors which we reinforce positively as well as inappropriate behaviors that may receive a consequence (natural or programmed).

Cognitive Behavioral Approach: What a person thinks is happening is more important than what is actually happening. Systematic study of self-reports suggests that an individual's belief system (thoughts about themselves and how they view the world and others around them), expectancies, and assumptions exert a strong influence on the well-being of the person, as well as on the persons directly observable behavior. An individual's belief system is contrived from what they learn from others as well as what they learn through their experiences growing up. Hence, most behavior is learned. When working with the individual served staff must understand that the individuals' behavior is influenced by their learned belief system (automatic thoughts) which triggers a healthy or unhealthy emotional response to that thought. From the perspective of the cognitive model, one may usefully construe irrational behavior in terms of the person's

distinctive concepts of self and of the animate and inanimate environment. The individual's belief systems may be grossly contradictory; i.e., he may simultaneously attach credence to both realistic and unrealistic conceptualizations of the same event or object. This inconsistency in beliefs may explain, for example, why an individual may react with fear to an innocuous situation even though he may also acknowledge that this fear is unrealistic. The basic premise is that people often have thoughts or feelings that perpetuate problematic or destructive beliefs and these faulty beliefs can affect functioning and relationships at home, work, school and in the community at large. Fundamentally, if one can change their thoughts, then their can change their feelings about a situation so therefore they can change their response to that situation or event which can inevitably change their life.

For example: Imagine it's your birthday. You're expecting a phone call from a close friend, but it never comes. You called them on their birthday, so why didn't they call you? Do they not care enough to remember your birthday? You feel hurt.

Where did this feeling of hurt come from? It wasn't the lack of a phone call that caused the hurt. It was the thoughts about the lack of a phone call that hurt. What if, instead of taking the missing phone call personally, you had thought:

- "My friend is so forgetful! I bet they don't know anyone's birthday."
- "Maybe something came up unexpectedly, and they're busy."
- "We did talk earlier in the week, so I guess it isn't a big deal."

Thoughts play a powerful role in determining how people feel and how they act. If someone thinks *positively* about something, they'll probably feel positively about it.

Conversely, if they think *negatively* about something—whether or not that thought is supported by evidence—they will feel negatively.

Core Beliefs and Perceptions

The thoughts we have in any given situation are influenced by our *core beliefs or how we perceive situations or other people*. These are beliefs that we hold at the center of who we are that describe the basic nature of the world. Some examples of common core beliefs are:

"People are generally good."

"I am unlovable."

"Everything turns out OK in the end."

"The world is a dangerous place."

Core beliefs are developed from a person's unique personal experiences. However, these beliefs aren't always accurate. For example, someone who was mistreated by a parent as a child might develop the belief that they are unlovable, when the problem was actually their parent.

Imagine your core beliefs are like a filter that each thought must pass through. If someone has the core belief that they are unlovable, each of their thoughts will have to make sense in the context of that belief. The process might look something like this

Situation: Michelle and Audrey both call a friend who does not answer the phone.	
Michelle	**Audrey**
Core Belief: I believe that I'm unlovable, so how does this situation make sense with my belief?	**Core Belief:** I believe that I'm valuable, so how does this situation make sense with my belief?
Thought: "My friend didn't answer the phone because she doesn't like me."	**Thought:** "My friend didn't answer the phone because she's busy or just not in the mood to talk. She'll probably call back, and if not, I'll call her again tomorrow."

Now, look at how the same negative core belief could impact even a positive situation:

Situation: Michelle calls a friend who answers the phone and has a nice conversation

Core Belief: I believe that I'm unlovable, so how does this situation make sense with my belief?

Thought: "My friend is really nice to put up with me. She's probably so annoyed by my phone calls. I should try not to bother her so much!"

Below is a simple model for changing thought patterns by developing three specific skills:

1. Catch the thoughts - become more aware of thoughts.
2. Check the thoughts - question the accuracy of your assumptions and interpretations.
3. Challenge the thoughts – actively challenge thoughts that are unhealthy for you.

Example: Thought Record				
Situation	**Thoughts**	**Emotions**	**Behaviors**	**Alternate Thought**
Everyone's busy, so I'm spending an evening alone with no plans.	No one wants to hang out with me. I'm just wasting my life, sitting here alone.	Depressed	Stayed home all night and did nothing. Just sat around having bad thoughts.	I'm alone tonight, but everyone is alone from time to time. I can do whatever I want!
A difficult assignment is due at school.	This is so much work. I'm horrible at this stuff. I don't think I can do it.	Anxious	Avoided the assignment until the last minute. Had to rush my work.	This is a difficult assignment, and it'll take a lot of work. But I know I can do it if I break it into small pieces.

Thought Record Instructions		
Columns	**Instructions**	**Example Entry**
Situation	Describe the situation that led to unwanted emotions or behaviors. Record only *the facts of what happened*, without any interpretation.	I received negative feedback about a report I wrote at work.
Thoughts	Thoughts are like an inner monologue. They can be statements or questions.	I really messed this up. I don't think I'm cut out for this job. Will they fire me?
Emotions	Write a single word or a description of a feeling. If your feelings changed throughout the experience, describe that process.	Felt bad about myself. Anxious.
Behaviors	Record what you did in response to the	I procrastinated on fixing my

	situation.	work because it seemed so daunting. This made everything worse!
Alternate Thought	What's a different thought you could've had? The goal isn't to be overly positive—you just want to be fair.	I made a mistake on my work, but it isn't that big of a deal. I'll correct it, and no one will care in a few days.

(Retrieved from http://www.therapistaid.com/therapy-guide/cbt-for-anxiety)

(Use "Thought Record" Activity – Discuss how beliefs and automatic thoughts affect emotions and behaviors and how to teach consumers to challenge those thoughts)

(4)Staff will demonstrate competence in identifying how anger, fear, and other emotions affect escalating behavior. [27E .0107(g)(2)(7)]

Stress, losses, fears and lack of control over what goes on in life can lead to feelings of anger and hostility. The anger and hostility can be there even though there is nothing going on at the time to account for it. But here's the thing: Anger isn't always a bad thing. When controlled, anger helps us. Anger drives us to make changes to situations that are bad, it pushes us to stand up for our rights, and it protects us if our lives are threatened. It is okay for you to feel anger as it is okay for the people we serve to feel anger. The problem isn't having anger, it's having too much anger, and expressing it in an ineffective way.

What can we do about anger: Anger management teaches us to deal with our anger in a healthy way. Like the name implies, it teaches us to manage our anger, not extinguish

it. Anger management begins with practicing self-awareness--learning to take a step back and see your anger before it takes over your mind. Next, once you've learned to catch your anger early, you'll learn techniques to control it.

Sometimes, you notice cracks and small leaks in the dam, which you can easily patch. But if you don't pay attention, the dam will burst, and there's no stopping the torrential flow of water that will follow.

If you catch your anger before it explodes, you will be able to control it. If you wait too long, there's little you can do to stop it. When you feel yourself getting angry – think about what is making you angry; pushing your buttons or triggering that anger; do you notice changes in your voice and body language?; What you need to do to control your anger?

How about the person you serve – If they are getting angry – How do you respond? Think about what is making them angry – Pay attention to what may be pushing their buttons or triggering the anger – Think about their normal reactions when they get angry – Make sure that you are not the issue or concern that is triggering their anger – Remove yourself from the situation while making sure it is safe to do so – If not then use a low tone of voice; make sure you are standing at least one and a half feet away from the person and; offer choices other than hostility and aggression to the person.

Because of this, learning to catch your anger early will be the most important skill you learn in anger management.

(Retrieved from http://www.therapistaid.com/therapy-guide/anger-management/anger/none)

(5)Staff will demonstrate competence in identifying ways to recognize health issues that may contribute to the person's behavior. [27E .0107(g)(2-3)]

HEALTH FACTORS THAT INFLUENCE BEHAVIOR

Health issues and other associated factors can influence the behavior of both staff and people who they serve.

Pain - Chronic pain is experienced not only as bodily discomfort but also as fears about the future, work impairment, threats to family bonds and activities, and assaults on the priorities of one's daily life. How an individual reacts to physical symptoms—be they pain or any other symptom—depends on his or her past experience with illness, personality and coping styles, familial and cultural norms, and current interpersonal interactions. Although pain is subjective, it is the outward expression—the observable illness behaviors—of the patient in pain (rather than any subjective state or physiological indicator) that defines the severity of the problem for others. Particular words chosen by the person to describe his or her pain let others know about the experience. Movements and body postures, as well as nonverbal vocalizations (sighing, groaning) are also powerful indicators of pain states. Body language expressive of pain may include posturing, bracing, grimacing, rubbing, gasping, or withdrawal from normal activity

Just like everyone else, health and physical condition affect how people with disabilities act toward others. Also, health issues may make it hard for you and the person to communicate with each other. It is important to rule out health issues before defining something as challenging or possibly aggressive behavior. If the person cannot tell

you that he/she is ill, it is important to know that person well enough to read the signs. Then you can change your expectations. For example, a person who is in bed with a headache may not want to get up to participate in normal routines. You may be able to avoid trouble by letting the person stay in bed. Think about the effects of:

- poor eyesight
- poor hearing
- difficulties grasping things
- difficulties walking
- illnesses related to poor health care and hygiene
- side effects of medications
- intoxication
- withdrawal
- energy level – no sleep; tired
- illness - Colds, flu, headaches, indigestion and other illnesses can cause reactions like grouchiness, crying or short temper. These reactions may be important indicators that the person is ill.
- Hunger - Hungry people are often difficult to deal with. A good meal can affect more than our mood, it can also influence our willingness to take risks.

(Retrieved from NCI Participant Workbook 2003)

It's no secret being hungry can affect your overall mood, resulting in an emotion sometimes described as "hangry," but it could also be making you engage in risky behavior. According to the American Dietic Association when [blood sugar] is low the

hypothalamus is triggered and levels of several hormones such as growth hormone, leptin and ghrelin are affected. This imbalance then causes a shift in neurotransmitters and suppresses serotonin receptors.

Serotonin is a hormone that helps regulate mood and appetite. Cut off your body's ability to process it, and prepare for some mood swings. Anger and extreme frustration, are common responses.

(Retrieved from https://www.mpg.de/7422218/hunger-behavior)

HOW STRESS INFLUENCES BEHAVIOR

Stress symptoms may be affecting your health, even though you might not realize it. You may think illness is to blame for that nagging headache, your frequent insomnia or your decreased productivity at work. But stress may actually be the culprit.

Common effects of stress

Stress happens when day-to-day demands become overwhelming, unpredictable, or out of control. Stress symptoms can affect your body, your thoughts and feelings, and your behavior. Being able to recognize common stress symptoms can give you a jump on managing them. Stress that's left unchecked can contribute to many health problems, such as high blood pressure, heart disease, obesity and diabetes.

Common effects of stress on your body

- Headache
- Muscle tension or pain
- Chest pain
- Fatigue
- Change in sex drive

- Stomach upset
- Sleep problems

Common effects of stress on your mood

- Anxiety
- Restlessness
- Lack of motivation or focus
- Feeling overwhelmed
- Irritability or anger
- Sadness or depression

Common effects of stress on your behavior

- Overeating or under eating
- Angry outbursts
- Drug or alcohol abuse
- Tobacco use
- Social withdrawal
- Exercising less often

Think about stressful things in your life:

- Are you facing a major change? Moving? Marriage? Divorce? Having

Individual's? Individual's leaving home?

- Are you dealing with a chronic illness?
- Are you caring for an elderly parent?
- Are you holding two jobs in order to pay the bills?
- Are your Individual's having trouble in school?

- Are you having car trouble so that getting to work is a problem?
- Are you having trouble with a co-worker or a supervisor?

Think about stressful things in your job:

- Is your workplace too crowded? Noisy? Hot? Cold?
- Do you feel like management doesn't listen to you?
- Do you feel like you are working harder with less help?
- Is everything done the way you want?
- Are you worried about keeping your job?

(Retrieved from NCI Participant Workbook 2003)

Managing stress

If you have stress symptoms, taking steps to manage your stress can have numerous health benefits. Explore stress management strategies, such as:

- Regular physical activity
- Relaxation techniques, such as deep breathing, meditation, yoga, tai chi or getting a massage
- Keeping a sense of humor
- Socializing with family and friends
- Setting aside time for hobbies, such as reading a book or listening to music

Aim to find active ways to manage your stress. Inactive ways you may use to manage stress — such as watching television, surfing the Internet or playing video games — may seem relaxing, but they may increase your stress over the long term.

And be sure to get plenty of sleep and eat a healthy, balanced diet. Avoid tobacco use, excess caffeine and alcohol intake, and the use of illicit substances.

Dealing with Burnout

Burnout is not a simple result of long hours. The cynicism, depression, and lethargy of burnout can occur when you're not in control of how you carry out your job, when you're working toward goals that don't resonate with you, and when you lack social support. If you don't tailor your responsibilities to match your true calling, or at least take a break once in a while, you could face a mountain of mental and physical health problems. Caring for people can be filled with blessings, meaningful experiences, and peace of mind, but also exhaustion that can lead to depletion. We know the toll that care giving takes on families during short or long term illnesses. However, healthcare workers often experience the same stresses on a daily basis.

Self- Care

Key to emotional self-care is making time to routinely express, soothe, and release emotions, including grief. Identifying individual emotional stress indicators, such as increased crying, irritability, anxiety, numbness, self-doubt, or addictive behaviors, is important.

- ***Expressing and Soothing:*** Cry when you must even if a movie or music is needed to "jump-start" a good cry. Other methods include writing, creating, listening to music, talking with confidants, enjoying hot baths, being held, or cuddling a pet, aromatherapy, massage, meditation, mindfulness, prayer, gardening, and even cleaning.
- ***Soaking up joy*:** Treasure the joyful times and successes you experience, as well as pleasurable activities and laugh often – these will fill up your resource reserves.

- ***Be mindful of warning signs:*** Relational warning signs include: Overextending one's self, inability to set limits, and instead of handling conflicts focused on solutions – you find yourself blaming or personalizing.

(Retrieved from http://www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/stress-symptoms/art-20050987)

Spiritual Self-Care

Healthcare is often spiritually rejuvenating, since it involves persons' big-picture concerns. However these can get lost in the details of paperwork and finding resources. As such, staying attuned spiritually is important. This includes reading sacred texts, praying, attending services, connecting to nature, listening to music, meditating, and engaging in creative endeavors."

(Lecavalier, Leaone and Witz (2006). The impact of behaviour problems on caregiver stress in young people with autism spectrum disorders. Journal of Intellectual Disability Research. Volume 50 Paert 3 pp 172-183)

(http://www.reducingdistress.co.uk/reducingdistress/wp-content/uploads/2014/02/Meeting_needs_and_reducing_distress.pdf)

CULTURAL BACKGROUND

Cultural background constitutes the ethnic, religious, racial, gender, linguistic or other socioeconomic factors and values that shape an individual's upbringing. A cultural background can be shaped at the family, societal or organizational level. Examples of different cultural groups include Vietnamese, English, African American and Irish Catholic. Cultural background is an important way to define an individual's identity.

People of different cultural backgrounds often have to interact with each other. These interactions may lead to strong relationships that help build diverse communities capable of achieving substantial goals. For instance, it may be necessary to work effectively with people from divergent races or with those who speak a different language to promote economic development and health care within a community or secure a good education for Individual's.

While it is important to learn about the cultures of other people to succeed in working together, one must first understand his own culture before he can appreciate any other. This understanding starts with recognition of the values, customs and world views passed down from grandparents or parents or those acquired from personal experiences while growing up in a given society. One can learn about culture by meeting people of other cultures, evaluating any biases towards other cultures, asking questions and reading.

Stereotypes, Prejudice and Racism,

An example of cognitive diagnoses of modern individual prejudice\ aversive racism focuses on the tension between not wanting to be racist and simultaneous\unconscious cognitions that reflect racism (The difference between aversive racists and non-racists lies in the extent of their willingness to confront their unconscious biases) Although not formally assessing individual differences\ this theory does focus on comparing traditional overt racists and modern subtle racists\ and it focuses on individual cognition more than on motivational issues.

Stereotype

In social psychology, a stereotype is any thought widely adopted about specific types of individuals or certain ways of behaving intended to represent the entire group of those individuals or behaviors as a whole.[1] These thoughts or beliefs may or may not accurately reflect reality

Prejudice

an affective feeling toward a person or group member based solely on their group membership. The word is often used to refer to preconceived, usually unfavorable, feelings toward people or a person because of their sex, gender, beliefs, values, social class, age, disability, religion, sexuality, race/ethnicity, language, nationality, beauty, occupation, education, criminality, sport team affiliation or other personal characteristics. In this case, it refers to a positive or negative evaluation of another person based on their perceived group membership.

Prejudice can also refer to unfounded beliefs and may include "any unreasonable attitude that is unusually resistant to rational influence". Gordon Allport defined prejudice as a "feeling, favorable or unfavorable, toward a person or thing, prior to, or not based on, actual experience". For the evolutionary psychology perspective, see Prejudice from an evolutionary perspective. Auestad (2015) defines prejudice as characterized by 'symbolic transfer', transfer of a value-laden meaning content onto a socially formed category and then on to individuals who are taken too belong to that category, resistance to change, and overgeneralization

(Rosnow, Ralph L. (March 1972). "Poultry and Prejudice". Psychologist Today. 5 (10): 53–6)

Racism

Is a discrimination and prejudice towards people based on their race or ethnicity. The ideology underlying racist practices often includes the idea that humans can be subdivided into distinct groups that are different in their social behavior and innate capacities and that can be ranked as inferior or superior.[2] The Holocaust is a classic example of institutionalized racism which led to the death of millions of people based on race. While the concepts of race and ethnicity are considered to be separate in contemporary social science, the two terms have a long history of equivalence in both popular usage and older social science literature. Racist ideology can become manifest in many aspects of social life. Racism can be present in social actions, practices, or political systems (e.g., apartheid) that support the expression of prejudice or aversion in discriminatory practices. Associated social actions may include nativism, xenophobia, otherness, segregation, hierarchical ranking, supremacism, and related social phenomena.

(Allport, Gordon (1979). The Nature of Prejudice. Perseus Books Publishing. p. 6. ISBN 0-201-00179-9.)

(10)Staff will demonstrate competence in identifying ways to effectively respond to issues particular to each person being served. [27E .0107(g)(1)(6-7)]

When working with a person who has a mental illness, developmental disability, or substance use disorder their specific challenge can affect how he/she thinks, interacts with others, works or goes to school, and participates in community life, keep in mind that we are all more alike than different. Each person comes to a new situation, school, job or program with unique skills and abilities. Staff can build on current competencies

while gaining new skills relating to the individuals they serve. People who interact with people who have disabilities have a great impact on the success of that person.

(Gething, L. (1992). Person to Person: A Guide for Professionals Working with People with Disabilities. Belmont, CA. Brookes Publishing Company)

How you think about the behaviors and habits of others can influence how you think about and respond to them. Look over this list to see if you recognize any of the differences between "WE" and "THEY" Think about what you might do to change how you think

WE	**THEY**
like things	fixate on objects
try to make friends	seek attention
love people	develop dependencies
take a break	go off task
insist	have tantrums
stand up for ourselves	are non-compliant
change our minds	have short attention spans

(Retrieved from NCI Participant Workbooks (2003) – Prevention - Public Domain)

Many providers use team work environments to maximize the potentials of their employees; this structure allows employees to work together to maximize individual strengths while compensating for weaknesses.

Expect that people with disabilities participating in a work-based learning experience are there to succeed. Keep your expectations high. Be positive and proactive in helping them achieve success. Career counselors and employers who follow the succeeding suggestions can help persons with disabilities accomplish just that.

- Do not exhibit the dramatic, "Oh my _____, if I was _____ I wouldn't be able to _____ " syndrome! Most likely the participant with a disability has a full life and has learned to positively meet the challenges posed by the disability.
- Avoid labels for groups of people with disabilities such as "the blind" or "the deaf." Instead, say "people who are blind" or "people who are deaf." Never use the terms "deaf and dumb."
- Avoid emotionally-charged descriptors such as "bedridden," "homebound," "crippled," "unfortunate," "pitiful," "stricken with," "wheelchair-bound," or "confined to a wheelchair." Instead, simply be descriptive such as "he uses a wheelchair."
- Avoid euphemisms to describe disabilities. Terms such as "handicapable," "differently-abled," "physically challenged," and "physically inconvenienced" are considered by many to be condescending. They reinforce the idea that disabilities cannot be dealt with in a straight-forward manner.
- Speak directly to a person and focus on her abilities rather than her disability.
- People who have disabilities have the same range of likes and dislikes as those who do not. Not all blind people are musical; not all people who use wheelchairs play wheelchair basketball; and not all deaf people read lips. Talk about things you talk about with other employees -- weather, sports, politics, what you did today.

- If you are feeling uncomfortable about a situation, let the person who has a disability know.
- Be sure expectations such as job performance, behavior, and dress are clearly defined, and that they are met.
- Provide specific feedback on job performance. If you have concerns about performance, mention it. The person may not know he is doing something incorrectly.
- If a person appears to be having difficulty at a task, he probably is. Ask if, and how, you may help.

(Retrieved from https://www.skillsyouneed.com/ips/conversational-skills.html)

Ways to learn more about each person you care for/treat/support.

One of the most important things you can do in your time with a person with disabilities is to get to know that particular person to be able to identify how anger, fear, and other emotions affect when their behaviors are escalating. To be able to identify these and other emotions in the person you serve will assist you with knowing and understanding what behaviors accompany those emotions in that particular person and will help that person to de-escalate any aggression or inappropriate behaviors. For example, you may know in general how a person with that specific diagnosis usually acts in a certain situation, but maybe this specific person is different. Taking lime to get to know someone shows respect. It also gives valuable insights into what has meaning for this person. You can use what you know to help the person learn new skills and improve the quality of his or her life.

Spend time with the person getting to know his/her life stories, hopes, fears, favorite foods, favorite people, favorite places. Sharing some of yourself can help too (your favorite foods, people, places, etc.). However be careful with self-disclosure that turns the attention away from the person being served to you. Doing things with the person rather than to or for the person, begins to build a relationship. Through this relationship you can begin to model ways to cope with life's difficulties and manage personal challenges (money, health, anger, etc).

Review the person's records — How a person came to be who they are is important. Evaluation reports can help too. Historical data or information on a person can be very informative however this is information that may tell you about the persons past life experiences and other peoples impression of that person at a certain moment in time but it does not tell you who they are today

Talk to family, friends, and other staff members — Families have known this person the longest. Families can provide unique insights and valuable perspectives. Respect the family's viewpoint. They have probably been through a lot. Also compare your observations with other staff members. Everyone sees people a little differently. Also understand others will have a different relationship with that person than you.

(Retrieved from NCI Participant Workbooks (2003) – Prevention - Public Domain)

(6)Staff will demonstrate competence in identifying ways that environmental and organizational factors can affect the way a person acts and reacts. [27E .0107(g)(2)(5)]

How provider agency organizational factors affect staff:

Individual behavior is influenced by a wide variety of organizational systems and resources.

1. Physical Facilities:

The physical environment at a work place is the arrangement of people and things so that is has a positive influence on people. Some of the factors which influence individual behavior are noise level, heat, light, ventilation, cleanliness, nature of job, office furnishing, number of people working at a given place etc.

2. Organization Structure and Design:

These are concerned with the way in which different departments in the organization are set up. What is the reporting system? How are the lines of communication established among different levels in the organization? The behavior and performance of the individual is influenced by where that person fits into the organizational hierarchy.

3. Leadership:

The system of leadership is established by the management to provide direction, assistance, advice and coaching to individuals. The human behavior is influenced to a large extent by the behavior of the superiors or leaders. Behavior of the leaders is more important than their qualities.

4. Reward System:

The behavior and performance of the individuals is also influenced by the reward system established by the organization to compensate their employees.

(Retrieved from http://www.washington.edu/doit/strategies-working-people-who-have-disabilities)

Think about how the organizational factors of your agency affect the people you serve?

How Organizational factors affect people you serve

Individual's that receive services and supports through some agencies provide periodic (day) services while others provide *wrap around 24-7* services and supports. The agency's organizational culture can influence the lives of people being served. Here are some ways an organization's culture affects people with disabilities.

Laws, rules standards, policies and procedures regulate agencies

In order to stay in business, agencies must make sure regulations are being met. At times there may be conflict between what makes sense for the person with *a* disability and what makes sense for the agency. For example, regulations may direct the agency to have a nutritionist plan healthy meals that promote proper weight. However, the person with disabilities may love pizza, burgers and milkshakes and hate green vegetables. If he/she is 15 pounds overweight and could care less about a diet, this could be a conflict between the wants of the person and the agency's compliance to a regulation

Documentation

Another issue is the amount of time you spend on documentation and scheduling. There are progress notes, log notes, medical record documentation, requisition forms, special authorizations for travel and the list goes on. You and others may feel that you spend more time filling out forms and writing notes than spending time with the people you are hired to serve. Along with the documentation is the issue of schedules. There are staff schedules, activity schedules, scheduling visits to doctors

and therapists and others. What happens in an organization and to people being served when log notes are not done or a schedule gets messed up? The organizational pressure to keep your documentation and schedules up-to-date puts pressure on you to put those things first. Conflicts with the people who need you are bound to arise.

(Retrieved from NCI Participant Workbooks (2003) – Prevention - Public Domain)

PART I UNIT TWO
FORMING THERAPEUTIC AND AFFIRMATIVE RAPPORT

Key Points

1. **When working with individuals with disabilities, it is important to remember all the different ways that we communicate effectively throughout our day. Our communication skills build and maintain relationships and help us meet our wants and needs**
2. **Common barriers to effective communication are using jargon, taboos, lack of attention, interest, distractions, or irrelevance to the receiver. Differences in perception and viewpoint, physical disabilities such as hearing problems or speech difficulties or physical barriers to non-verbal communication**
3. **Cultural differences, expectations and prejudices may lead to false assumptions or stereotyping**
4. **Active listening involves listening with all senses. As well as giving full attention to the speaker, it is important that the 'active listener' is also 'seen' to be listening - otherwise the speaker may conclude that what they are talking about is uninteresting to the listener**

5. **Body movements can be used to reinforce or emphasize what a person is saying and also offer information about the emotions and attitudes of a person**
6. **A therapeutic relationship aims to achieve goals and solve problems on behalf of one of the people. Make sure that the environment is as safe as possible; Take the whole person into account and; Making sure the people involved have a say in their own goals**

(7)Staff will demonstrate competence in identifying behavioral ways that people communicate wants and needs. [27E .0107(g)(2)(6)(7-8)]

Many people take for granted their ability to communicate. From the moment we get up to the time we put our heads back on the pillow we are constantly communicating to those around us. Some of this dialogue takes place with verbal exchanges, some with gestures (to the cab driver that passed you by), facial expressions (a friendly smile to the coworker you want to greet but can't stop and talk to), notes passed back and forth (while sitting next to a colleague during the extra long staff meeting), and the list goes on.

Technologically, we've evolved to where many people prefer to use technology as their main form of communication. I'd be lost without my iPhone for texting, e-mail, as well as access to Facebook and Skype to keep up with friends and family.

When working with individuals with disabilities, it is important to remember all the different ways that we communicate effectively throughout our day. Our communication skills build and maintain relationships and help us meet our wants and needs.

Therefore, we should apply the same idea when thinking about our consumers and their communication needs. By broadening our idea of effective communication from just "speech" to any means that appropriately, effectively and efficiently gets the desired message across we open up an array of modalities to try with these students. When we transition from a "must learn to speak" communication plan to a "must learn to communicate" plan, we often see frustration decrease, behaviors decrease, communication increase, and even verbal speech increase. Overall the child and those working with him become more successful.

Children demonstrate a desire to gain access to things they like such as food, toys and attention from parents very early in life. They also begin to understand and seek the completion of an activity, or demonstrate avoidance of what is to come next in their day if it is not a preferred activity. Without a way to appropriately express themselves, these desires often manifest in the form of behaviors such as hitting themselves or others, screaming, crying, biting, destroying things around them, running away, etc. This is our indication that it is time to begin implementing a functional communication system. It also points to the diligence needed in pro-actively implementing communication systems prior to the escalation of behaviors.

(Retrieved from https://www.skillsyouneed.com/ips/body-language.html)

(8)Staff will demonstrate competence in identifying behaviors and attitudes that create barriers to positive interaction. [27E .0107(g)(2-6)]

Common Barriers to Effective Communication

The use of jargon. Over-complicated, unfamiliar and/or technical terms

Emotional barriers and taboos Some people may find it difficult to express their emotions and some topics may be completely 'off-limits' or taboo

Lack of attention, interest, distractions, or irrelevance to the receiver.

Differences in perception and viewpoint

Physical disabilities such as hearing problems or speech difficulties

Physical barriers to non-verbal communication. Not being able to see the non-verbal cues, gestures, posture and general body language can make communication less effective

Language differences and the difficulty in understanding unfamiliar accents

Expectations and prejudices which may lead to false assumptions or stereotyping. People often hear what they expect to hear rather than what is actually said and jump to incorrect conclusions

Cultural differences. The norms of social interaction vary greatly in different cultures, as do the way in which emotions are expressed. For example, the concept of personal space varies between cultures and between different social settings.

(Retrieved from https://www.skillsyouneed.com/ips/barriers-communication.html)

(9)Staff will demonstrate competence in identifying verbal and non-verbal communication strategies/skills that promote positive interactions with people. [27E .0107(g)(4)(8-9)]

Positive Interaction Strategies

Conversation is a Two-Way Street - The first and most important rule of conversation is that it is not all about you, but it's not all about the other person either.

A monologue, in either direction, is not conversation. Try to achieve a balance between talking and listening in any conversation

This is where social media makes life difficult. We're used to broadcasting our views, and then responding if others comment. That can feel like the start of a conversation but, when you're face to face, it's not polite to start by broadcasting your views

Instead, try asking a question to establish common ground. For example: "*What do you do?*", or even "*Isn't the weather beautiful?*"

This signals your intention to share the conversation

Active Listening

Active listening involves listening with all senses. As well as giving full attention to the speaker, it is important that the 'active listener' is also 'seen' to be listening - otherwise the speaker may conclude that what they are talking about is uninteresting to the listener

Interest can be conveyed to the speaker by using both verbal and non-verbal messages such as maintaining eye contact, nodding your head and smiling, agreeing by saying 'Yes' or simply 'Mmm hmm' to encourage them to continue. By providing this 'feedback' the person speaking will usually feel more at ease and therefore communicate more easily, openly and honestly

(Retrieved from https://www.skillsyouneed.com/ips/active-listening.html)

Body Language or Body Movements (Kinesics)

Body movements include gestures, posture, head and hand movements or whole body movements. Body movements can be used to reinforce or emphasize what a person is saying and also offer information about the emotions and attitudes of a person.

However, it is also possible for body movements to conflict with what is said. A skilled observer may be able to detect such discrepancies in behavior and use them as a clue to what someone is really feeling and thinking

There are several different categories of body movement, these include:

Emblems

Gestures that serve the same function as a word are called emblems

For example, the signals that mean 'OK', 'Come here!', or the hand movement used when hitch-hiking. However, be aware that whilst some emblems are internationally recognized, others may need to be interpreted in their cultural context

Illustrators

Gestures which accompany words to illustrate a verbal message are known as illustrators

For example, the common circular hand movement which accompanies the phrase 'over and over again', or nodding the head in a particular direction when saying 'over there'

Regulators

Gestures used to give feedback when conversing are called regulators

Examples of 'regulators' include head nods, short sounds such as 'uh-huh', 'mm-mm', and expressions of interest or boredom. Regulators allow the other person to adapt his or her speech to reflect the level of interest or agreement. Without receiving feedback, many people find it difficult to maintain a conversation. Again, however, they may vary in different cultural contexts

Adaptors

Adaptors are non-verbal behaviors which either satisfy some physical need

Adaptors include such actions as scratching or adjusting uncomfortable glasses, or represent a psychological need such as biting fingernails when nervous

Although normally subconscious, adaptors are more likely to be restrained in public places than in the private world of individuals where they are less likely to be noticed.

Adaptive behaviors often accompany feelings of anxiety or hostility

Posture

Posture can reflect emotions, attitudes and intentions

Research has identified a wide range of postural signals and their meanings, such as:

Open and Closed Posture

Two forms of posture have been identified, '*open*' and '*closed*', which may reflect an individual's degree of confidence, status or receptivity to another person

Someone seated in a closed position might have his/her arms folded, legs crossed or be positioned at a slight angle from the person with whom they are interacting. In an open posture, you might expect to see someone directly facing you with hands apart on the arms of the chair. An open posture can be used to communicate openness or interest in someone and a readiness to listen, whereas the closed posture might imply discomfort or disinterest

Mirroring

Notice the way a loving couple relate to each other. You might like to observe a close relationship in person or on television. You will see that the partners' postures will match, as if one partner is a mirror reflection of the other. For example, if one partner drapes an arm over the back of a chair this might be replicated in the other person's

position. If one partner frowns, it could be reflected in the other partner's facial expression. This 'mirroring' indicates interest and approval between people

Closeness and Personal Space (Proxemics)

Every culture has different levels of physical closeness appropriate to different types of relationship, and individuals learn these distances from the society in which they grew up The study of personal space is called proxemics

In today's multicultural society, it is important to consider the range of non-verbal codes as expressed in different ethnic groups. When someone violates an '*appropriate*' distance, people may feel uncomfortable or defensive. Their actions may well be open to misinterpretation

In Western society, four distances have been defined according to the relationship between the people involved

The Four Main Categories of Proxemics

These four distances are associated with the four main types of relationship - intimate, personal, social and public. Each of the distances is divided into two, giving a close phase and a far phase, making eight divisions in all. It is worth noting that these distances are considered the norm in Western society

Intimate Distance (touching to 45cm) - Intimate distance ranges from close contact (touching) to the 'far' phase of 15-45cm. In British society, it tends to be seen as an inappropriate distance for public behavior and entering the intimate space of another person with whom you do not have a close relationship can be extremely disturbing

Personal Distance (45cm to 1.2m) - The 'far' phase of personal distance is considered to be the most appropriate for people holding a conversation. At this distance it is easy

to see the other person's expressions and eye movements, as well as their overall body language. Handshaking can occur within the bounds of personal distance

Social Distance (1.2m to 3.6m) - This is the *normal* distance for impersonal business, for example working together in the same room or during social gatherings. Seating is also important; communication is far more likely to be considered as a formal relationship if the interaction is carried out across a desk. In addition, if the seating arrangements are such that one person appears to look down on another, an effect of domination may be created. At a social distance, speech needs to be louder and eye contact remains essential to communication, otherwise feedback will be reduced and the interaction may end.

Public Distance (3.7m to 4.5m) - Teachers and public speakers address groups at a public distance. At such distances exaggerated non-verbal communication is necessary for communication to be effective. Subtle facial expressions are lost at this distance, so clear hand gestures are often used as a substitute. Larger head movements are also typical of an experienced public speaker who is aware of changes in the way body language is perceived at longer distances

Understanding these distances allows us to approach others in non-threatening and appropriate ways. People can begin to understand how others feel about them, how they view the relationship and, if appropriate, adjust their behavior accordingly

Important Clues and Messages

Body language, posture and distance provide important information to supplement words, or verbal communication. They are a crucial addition to the overall message. The full picture also includes facial expressions, eye contact and voice

(Retrieved from https://www.skillsyouneed.com/ips/body-language.html)

(10)Staff will demonstrate competence in identifying ways to effectively respond to issues particular to each person being served. [27E .0107(g)(1)(6-7)]

Occasionally an individual may have, implicitly or explicitly, concerns that his or her attitudes, beliefs, thoughts, feelings, or actions (or lack thereof) may in some way be wrong, lacking, or not make sense. Validation serves to support the person by providing positive assurance that their feelings, actions, and thoughts are appropriate per their unique situation and perspective.

Normalizing is similar to validation. Whereas the purpose of validation is to honor the individual's perspective as appropriate for the individual, normalizing can be useful in instances when the individual considers his or her condition or symptoms as unique, atypical, or perhaps distressingly abnormal. As the therapist, you have the opportunity to provide a broader, more objective context, suggesting that although the individual's situation seems exceptional—perhaps in a negative sense—such conditions are considered within the boundaries of normality, that many others have similar experiences. Normalizing can be a particularly effective skill, especially when dealing with covert symptoms that may be non-visual or that may seem odd or embarrassing, wherein one cannot readily observe just how common such a phenomenon actually is.

(Knapp, Herschel. *Therapeutic Communication: Developing Professional Skills, 2nd Edition*. SAGE Publications, Inc, 03/2014. VitalBook file)

(11)Staff will demonstrate competence in identifying strategies that staff can use to communicate respect for people receiving services. [27E .0107(g)(1-4)]

Empathy, derived from the Greek word *empatheia* meaning "in feeling" is defined as "the ability to understand and share the feelings of another"

Empathy does not require or imply that you are committed to actually reproduce the individual's feelings within yourself but rather that you understand and are sensitive to the nature of what the individual is feeling. Essentially, empathy is about trying to comprehend the individual's experience from the individual's emotional standpoint, in essence seeing or feeling through the individual's eyes and conveying your perception to the individual. Communicating such comprehension demonstrates that you are acutely tuned in to the richness of the individual's experience. Demonstrating such attentiveness helps assure the individual that he or she is being taken seriously, thereby further developing a sense of rapport. Effective use of empathy has been shown to facilitate the therapeutic relationship, helping bridge gaps among individuals and therapists from different ethnicities. Empathetic communication has also been noted to reduce premature therapeutic termination

(Knapp, Herschel. *Therapeutic Communication: Developing Professional Skills, 2nd Edition*. SAGE Publications, Inc, 03/2014. VitalBook file)

Important Language Considerations in Developing Person-Centered Plans

Despite the fact that the process behind a recovery plan may be largely recovery-oriented, the translation of this process into the actual language of the planning document itself continues to be a core challenge of all providers who are committed to creating person-centered plans. The following are offered as overarching guidelines that should be considered regarding language that is incorporated in both written documents and verbal interactions. 1. The language used is neither stigmatizing nor objectifying. At

all times "person first" language is used to acknowledge that the disability is not as important as the person's individuality and humanity, e.g., "a person with schizophrenia" versus "a schizophrenic" or a "person with an addiction" versus "an addict." Employing person-first language does not mean that a person's disability is hidden or seen as irrelevant; however, it also is not be the sole focus of any description about that person. To make it the sole focus is depersonalizing and derogatory, and is no longer considered an acceptable practice. 2. The language used also is empowering, avoiding the eliciting of pity or sympathy, as this can cast people with disabilities in a passive, "victim" role and reinforce negative stereotypes. For example, just as we have learned to refer to "people who use wheelchairs" as opposed to "the wheelchair bound" we should refer to "individuals who use medication as a recovery tool" as opposed to people who are "dependent on medication for clinical stability." 3. Words such as "hope" and "recovery" are used frequently in documentation and delivery of services. 4. Providers attempt to interpret perceived deficits within a strengths and resilience framework, as this will allow the individual to identify less with the limitations of their disorder. For example, an individual who takes their medication irregularly may be automatically perceived as "non-compliant," "lacking insight," or "requiring monitoring to take meds as prescribed." However, this same individual could be seen as "making use of alternative coping strategies such as exercise and relaxation to reduce reliance on medications" or could be praised for "working collaboratively to develop a contingency plan for when medications are to be used on an 'as-needed' basis." 5. Avoid using diagnostic labels as "catch-all" means of describing an individual (e.g., "Is a 22-year-old borderline patient with…"), as such labels often yield minimal information regarding the

person's actual experience or manifestation of their illness or addiction. Alternatively, an individual's needs are best captured by an accurate description of his or her functional strengths and limitations. While diagnostic terms may be required for other purposes (e.g., classifying the individual to support reimbursement from funders), their use should be limited elsewhere in the person-centered planning document.

(Retrieved from Tondora, et al., (2007). Yale University School of Medicine Program for Recovery and Community Health. New Haven, CT.)

(Use "The Glass Half Empty, The Glass Half Full Activity" – Discuss the dangers of labeling and clinical speak)

(12)Staff will demonstrate competence in identifying strategies that staff can use to develop and maintain a relationship that focuses on the needs/personal goals of the individual receiving services. [27E .0107(g)(1)(4-6]

One of the most important parts of your job is working together with others in positive ways. Having positive relationships with people with disabilities will help you assist and support them. A therapeutic relationship aims to achieve goals and solve problems on behalf of one of the people.

Strategies for therapeutic relationships

- Make sure that the environment is as safe as possible. Make changes if someone has particular needs.
- Take the whole person into account. Remember, "people first" Everyone needs safety, privacy, respect and meaningful things to do
- Help make and keep orderly routines. Make sure the people involved have a say in their own goals, objectives and what they need

(Retrieved from NCI Participant Workbooks (2003) – Prevention - Public Domain)

(13)Staff will demonstrate competence in identifying the differences between a professional and social relationship with a person receiving services. [27E .0107(g)(1)(4-5)(9)]

Ethics fundamentally consist of a code of conduct that delineates right from wrong Personal ethics may be derived from one or several sources (e.g., values and practices inherited from one's family, community norms, religious/spiritual beliefs, personal beliefs, etc.); each individual is free to assemble and lead their life based on the ethical principle(s) of his or her own choosing.

In casual relations with loved ones, friends, and acquaintances, you are free to conduct yourself any way you see fit.

In the professional realm, various professions have developed and published a professional code of ethics to provide fundamental practice guidelines designed to facilitate quality service and professional integrity/reputation. While there is considerable variability among professional domains (e.g., clergy, education, legal, medical, psychological, etc.), most codes of ethics concur regarding:

- valuing honesty,
- individual autonomy/self-determination,
- competence,
- respect for others (individuals and colleagues),
- working within scope of practice,

- confidentiality,
- providing quality goods/services,
- managing conflicts of interest, and
- professional development.

Typically, we think of ourselves as free to select our friends at will based on personal preferences. A variety of things can attract us to an individual: similar interests, physicality (overall appearance, fashion, grooming, stature, etc.), talents, common backgrounds, ethnicity, attitudes, demeanor, and common friends. In a professional setting, there is usually no such privilege. In a professional setting, there is usually no such privilege. Your role as a therapist involves the commitment to provide quality care to individuals without bias with respect to age, ethnicity, culture, race, disability, gender, religion, sexual orientation, or socioeconomic status

Social relationships can begin in a variety of ways, such as introductions through friends; incidental conversations at parties, with coworkers, with fellow students; or Internet contact. In the professional realm, individuals may be self-referred or they may seek out a facility based on a referral from another such as a family member, significant other, friend, physician, or a member of the clergy.

Social relationships may end in a variety of ways for a variety of reasons, ranging from irreconcilable differences to geographical relocation. Such deliberate endings may be gradual or abrupt. Alternatively, people may drift apart or become more occupied with other people, projects, or interests. Unlike social relationships, which may last a lifetime, the professional therapeutic relationship is ultimately meant to be finite.

(Knapp, Herschel. Therapeutic Communication: Developing Professional Skills, 2nd Edition. SAGE Publications, Inc, 03/2014. VitalBook file)

PART I UNIT THREE
CONSTRUCTING SOLUTIONS

Key Points

1. Loss of control over daily and long range decisions can lead to loss of freedom, loss of privacy, loss of dignity and access to family and friends. These losses can lead to feelings of fear, panic, frustration and insecurity. These feelings can lead to poor behaviors such as aggression, withdrawal, manipulative behaviors and negative attention seeking behaviors
2. Strategies that can put people receiving service's back in "charge" are encouraging decision making; teaching problem solving; teaching appropriate and useful interpersonal skills and helping people to be resilient
3. We encourage decision making by offering hope; offering choices; avoiding unnecessary confrontation; helping people make their own decisions; avoid giving orders and; being positive when the person uses problem solving techniques to make a decision
4. When teaching problem solving we help the person: 1) State the problem or issue in clear terms; 2) List options; 3) Evaluate the options; 4) Choose and do and; 5) Evaluate the action

(14)Staff will demonstrate competence in identifying how a person's loss of control over daily and long range decisions can affect a person receiving services. [27E .0107(g)(1-3)(5-6)]

Taking Back Control of Your Life

Loss of control over decisions can cause feelings of fear, panic, frustration and insecurity. These feelings can lead to aggression, withdrawal, negative attention-seeking, manipulations and lack of cooperation.

Grief has its own category of treatment plans and possible interventions, yet those struggling with everyday losses often manifest grief like symptoms. Being laid off, losing a scholarship opportunity, aging — the list of grief-inducing experiences is infinite, and experts agree that these losses can launch us into the same grief process that accompanies the death of a loved one.

Losses

Loss of control over daily and long range decisions can affect a person receiving services. This is especially true of people living away from their own homes. Some examples of losses are:

- losing freedom of movement
- losing privacy
- losing dignity
- not being able to do things at the spur of the moment
- limits on personal possessions

- limits on access to family and friends
- not being able to meet the demands of everyday life on their own
- having to do what others say

The problem is that clients, and the communities they live in, often have different expectations for how we should respond in such moments.

Many individuals who experience mental health challenges, have disabilities, are in recovery or have had traumatic things happen to them feel that they have no power or control over their own lives. Control of their life may have been taken over when symptoms were severe and they were in a very vulnerable position. Family members, friends and health care professionals may have made decisions and taken action on their behalf because these symptoms may have been so intrusive they couldn't make decisions for themselves, others may have thought they couldn't make good decisions or didn't like the decisions the individual made. Even when the individual is doing much better, others may continue making decisions on their behalf. Often, the decisions that are made and the resulting action are not those the individual would have chosen.

Feelings based on losses

Loss of power and control over their lives affects how people with disabilities feel about themselves and about how they act with others. Some feelings are:

- fear
- panic or the feeling of being smothered or trapped and unable to express feelings
- frustration
- insecurity/not knowing what is expected

- feeling bad about themselves (lowered self-esteem)

People feeling fear, panic, frustration, insecurity or bad about themselves have a hard time behaving in a positive way. In fact, it is a set up to behave poorly. Some examples of poor behavior are:

- Aggression toward themselves or others
- Withdrawal from others
- Negative attention-seeking behaviors
- Manipulative behavior — using shrewd or devious behaviors to get needs met
- being uncooperative

Taking back control of their life by making their own decisions and making their own choices is essential to recovery. Making their own decisions can help the individual to feel better about themselves and may even help the individual to relieve some of the symptoms that have been troubling to them.

(Retrieved from NCI Participant Workbooks (2003) – Prevention - Public Domain)

(15)Staff will demonstrate competence in identifying strategies that can be used to put the person receiving services "in charge" of what is happening. [27E .0107(g)(1)(4)(6)]

Putting the person "in charge" that is receiving services means teaching and guiding them in decision making and problem solving

Teaching problem solving

You can teach problem solving. Help the person:

- State the problem; state what the person would like to have happen - say what he or she wants

- List options - explore ways to get what he or she wants

- Evaluate the options — figure out possible consequences of each

- Choose and do - choose what to do and act on that choice

- Evaluate the action - look at the consequences of the actions

(Retrieved from NCI Participant Workbooks (2003) – Prevention - Public Domain)

(Hand out information for the SURVIVAL A Simulation Game) – Discuss how problem solving steps were used in this activity

You can teach appropriate and useful interpersonal, social and self management skills. The key words here are *appropriate and useful.* Again, it's a matter of the people with disabilities being in charge. What do they think is appropriate and useful? How can you find out? What makes sense for one person might not make sense for another. It is important to always consider the whole person when providing services or supports. You must keep in mind how the person thinks, how the person feels and how the person functions in life. You can teach people new ways to behave, but if they feel like failures, chances are they won't try the new stuff. They will slip back into their old ways.

The whole person

Thinks — The person has to know the new skill.

Feels - The person's feelings have to allow him or her to try, fail and try again.

Does - The person has to be able to actually perform the skill.

(Retrieved from NCI Participant Workbooks (2003) – Prevention - Public Domain)

Helping Resilience

"Resilience is about developing and maintaining the strength to overcome adversity," explains Marymount University professor Tamara E. Davis, a member of ACA and the counselor educator vice president for the American School Counselor Association, a division of ACA. "In children, resilience can be developed by helping them develop the internal and external assets that will sustain them when life is difficult or when hard times occur. For adults, resilience typically comes through a sense of hopefulness and optimism about the present and future and the belief that one can overcome difficulties, either through prior experience in overcoming [difficulties] or through optimism that one can."

(Gething, L. (1992). Person to Person: A Guide for Professionals Working with People with Disabilities. Belmont, CA. Brookes Publishing Company)

(16)Staff will demonstrate competence in identifying strategies that can be used to empower and encourage people with disabilities in making their decisions. [27E .0107(g)(1)(4)(6)]

Encourage decision-making

You can encourage decision making by:

- offering hope
- offering choices
- avoiding unnecessary confrontation
- helping people make their own decisions
- having a good reason for your "orders" or avoiding them altogether
- saying or doing something positive when the person makes decisions helping people problem solve

There are several things you can do as staff to begin this process. You can do these things in whatever way feels right to you. You may want to assist the individual with using a journal to list or write their thoughts and ideas as a way to stay focused on what it is they want, to motivate them and to record their progress

Think about what you really want your life to be like.

Do you want to

- go back to school and study something of special interest to you?
- enhance your talents in some way?
- travel?
- to do a certain kind of work?
- have a different home space or to own your home?
- move to the country or the city?
- have an intimate partner?
- have children?
- work with an alternative health care provider on wellness strategies?
- make your own decisions about treatment?
- stop putting up with disabling side effects?
- become more physically active?
- lose or gain weight?

(Retrieved from NCI Participant Workbooks (2003) – Prevention - Public Domain)

PART I UNIT FOUR
CRISIS BEHAVIOR ASSESSMENT

Key Points

1. Factors such as low self-esteem, unresolved issues between staff and person served, feeling they are the only one taking care of the person and/or they voice negative comments concerning care of the person are signs that abuse of the individual in services is a possibility
2. You have a legal and ethical duty to report any one, including co-workers that are engaging in abusive behavior
3. If you recognize a co-worker having difficulties short of physical or verbal abuse you can suggest a "buddy system" to help; suggest they have a break; talk to them about it and notify your supervisor of the difficulties your co-worker may be having
4. Signals and cues that a person's aggressive behavior is escalating include both physical cues such as sweating clenched fists, shaking, rapid breathing, pacing, fidgeting. Behavioral changes include loud speech. finger jabbing, swearing, aggressive posture, tone of voice or kicking or banging things
5. "Fight or Flight" is a programmed response in times of crisis and fear. Families might teach that fighting is good; that only cowards talk or run

away. If fighting has worked out in the past, a person will tend to fight again. If running away has worked out, the person will tend to run away

6. **Triggers are environmental, situational or physical factors that set off an individual's challenging behavior. These factors vary depending on the individual, but they may include the care environment, interventions, activities, objects, thoughts, feelings, pain or discomfort**
7. **Staff attitudes and behaviors such as ignoring people, expecting absolute obedience, telling rather than asking, teasing or picking or making unreasonable or unenforceable consequences can tend to escalate behaviors in individuals we serve**
8. **Many factors influence a person's chance of developing a mental and/or substance use disorder. Effective prevention focuses on reducing those risk factors, and strengthening protective factors, that are most closely related to the problem being addressed**

(17) Staff will demonstrate competence in identifying behavioral cues that may indicate staff's distress, change in ability to cope, or possible loss of control. [27E .0107(g)(2)]

Teacher burnout was recently associated with behavior problems in Individual's with IDD, according to Lecavalier, Leaone and Witz (2006). In this study, which included some Individual's with ASDs, child behavior problems were associated with emotional exhaustion among teachers and teaching assistants who worked in special education

schools. Conduct problems and lack of pro-social behaviors were the most strongly associated with caregiver distress.

(Lecavalier, Leaone and Witz (2006). The impact of behaviour problems on caregiver stress in young people with autism spectrum disorders. Journal of Intellectual Disability Research. Volume 50 Paert 3 pp 172-183)

Behavioral Cues That May Indicate Staff Distress, Change in Ability to Cope 0r Possible Loss of Control

No one is denying the difficult nature of care giving tasks such as assisting with activities of daily living (ADL's) such as dressing, toileting and bathing. Staff's range of responsibilities may also include ensuring that medications are taken, transporting to and from appointments, shopping and handling the monthly expenses. Typical staff/caregiver stresses that may set the stage for abuse include anxiety or depression symptoms as well as poor nutrition, inadequate sleep and general fatigue. Most staff/caregivers manage to cope with these issues without resorting to verbal, physical or even financial abuse, but some can't.

What to Watch For

There are factors to watch for in the care giving relationship that could yield clues that abuse *could* occur. Here are a few staff/caregiver questions to ask:

- *Does the staff/caregiver suffer from low self-esteem?* This seems to be a risk factor for abuse but the research has not clarified whether the abuse is caused by the low self-esteem or if the opposite is true.

- *Are there unresolved issues from the past between the staff/caregiver and the person receiving care?* Having issues that are still not solved only places more pressure on the care giving relationship.
- *Does the staff/caregiver feel that they are the only one's providing service and do they perceive their role as burdensome?* Studies have shown that the risk for abuse increases as the amount of care needed increases.
- *Are there verbal warning signs from the staff/caregiver about potential behavior such as, "I am worried that one day I will just snap."* Research indicates that about 20 percent of the caregivers are worried that they could abuse their care recipient. That number swells to 57 percent if the caregiver has experienced abuse or violence from the person they are caring for.

When the answer to the above questions is "yes" and the person receiving the care has behavior problems or dementia, these can be further warning signs of potential danger. Social service organizations would term this scenario as an "at risk" family, where both parties could be volatile and prospectively hazardous to each other.

How to Reduce the Risk of Abuse

Each care giving dynamic is unique but there are a few general suggestions on abuse prevention:

1. Ideally, family members and provider agencies should observe for the "perfect storm" of circumstances where abuse may occur so an intervention can be planned.
2. Arrangements should be made for additional relief help from other staff/caregivers, to lighten the care giving load.

3. Attendance at support groups or educational sessions should be encouraged for staff/caregivers to learn beneficial coping skills.

You have ethical and legal issues to think about in this situation as well as loyalty to your co-workers. Legally, you are required to report abusive behavior. You will need to follow the law and your agency's procedures. You have a responsibility to see that people with disabilities are treated with respect and without harm, and your agency will hold you accountable for that.

If you notice that a co-worker seems to be having difficulty with others, you can set up a "buddy system" to help. That is, volunteer to work alongside the other person and be a role model. If you see something getting out of hand, you must step in to stop it and get the co-worker out of the situation. You can try to preserve dignity by suggesting a coffee break or that the person is needed elsewhere. Even if the situation did not include actual aggression, it would be helpful for you to sit down with the co-worker later to talk over what happened and how to avoid it in the future. In many cases, your supervisor needs to know what happened.

(Retrieved from http://www.eldercarelink.com/Other-Resources/Caregiving-Support/danger-at-home-when-caregiver-stress-leads-to-abuse.htm)

(18) Staff will demonstrate competence in behavioral cues of the person receiving services that may indicate distress, change in ability to cope, or possible loss of control. [27E .0107(g)(1-2)]

Usually, it is obvious when someone is aggressive, from his or her actions, words and/or expressions. It is important that anyone who finds themselves in such situations

does not respond aggressively to the aggressive behavior as it may only serve to reinforce such behavior. It is essential to watch for signals that might indicate that a person's aggression is escalating

Physical Changes	Behavioral Changes
Sweating / perspiring	Loud speech or shouting
Clenched teeth and jaws	Pointing or jabbing with the finger
Shaking	Swearing/verbal abuse
Muscle tension	Over-sensitivity to what is said
Clenched fists	Standing too close
Rapid breathing/sharp drawing in of breath	Aggressive posture
Staring eyes	Tone of voice
Restlessness, fidgeting	Problems with concentration
Flushed face or extreme paleness of face	Stamping feet
Change in Health of a Family Member	Banging/kicking things
Rise in pitch of voice	Walking away

Some of these responses are classed as open or direct responses and are more likely to be the reactions of aggressive individuals, for example clenched fists, swearing, verbal abuse, or the adoption of an aggressive posture. Over-sensitivity to what is said or crying is classed as passive or indirect responses, and are more likely to be associated with passive individuals.

You should be aware that the more extreme signals of aggression presented together might indicate that an individual is becoming increasingly agitated, and the potential for

this to develop into a risk situation should be seriously considered. Anyone working in situations where aggression leading to violence is a threat should make sure they have adequate protection.

(Retrieved from https://www.skillsyouneed.com/ps/dealing-with-aggression2.html)

(19) Staff will demonstrate competence in identifying reasons that people engage in challenging behaviors. [27E .0107(g)(1-2)]

People show distress through behavior escalation and aggression for a lot of reasons. One reason is the "fight or flight" response Animals and humans are programmed to do one of these in times of crisis and fear. Families might teach that fighting is good; that only cowards talk or run away. If fighting has worked out in the past, a person will tend to fight again. If running away has worked out, the person will tend to run away.

Understanding challenging behavior

'Challenging behavior' refers to any non-verbal, verbal or physical behavior by a person being served which makes it difficult to perform clinical tasks and/or poses a safety risk. It can describe actions, but can also include non-compliance, particularly if staff needs to intervene to deliver treatment or care.

There are different types of challenging behavior:

Non-verbal challenging behavior may include...wandering, pacing, cornering, intimidating facial expressions

Verbal challenging behavior may include...shouting, swearing, racist, sexist or offensive speech

Physical challenging behavior may include...scratching, biting, slapping, inappropriate touching, self harm, spitting, punching, hitting furniture

Why does it happen?

Individuals who display challenging behavior often have some degree of cognitive impairment, either long term (e.g. due to dementia, a mental health condition or learning disability) or short term (e.g. due to delirium, head injury, or drug/alcohol intoxication). There is always a cause of clinically related challenging behavior, even if it is not evident to staff at the time. Challenging behavior is often an expression of distress or an attempt by the person to communicate an unmet need. Identifying unmet needs and other reasons for challenging behavior in order to prevent distress should reduce the likelihood of unforeseen events. It is vital that staff take care in determining whether an Individual's behavior is a result of an illness or injury which requires urgent attention.

Identifying patterns

Searching for patterns to challenging behavior can help staff predict when challenging behavior is more likely, to plan and prepare, and to prevent it. For example, challenging behavior in many people has a tendency to occur during certain interventions, such as during care tasks, administration of medication, or at particular times of day, such as at mealtimes.

Knowing about triggers

Triggers are environmental, situational or physical factors that set off an individual's challenging behavior. These factors vary depending on the individual, but they may include the care environment, interventions, activities, objects, thoughts, feelings, pain or discomfort. For example, a person can become overwhelmed or distressed when a

group of healthcare professionals undertake a care intervention in close proximity to them.

Once identified, many triggers can be avoided. That is why observing, identifying and documenting potential triggers can be the first part of a proactive strategy for minimizing stressful or distressing situations.

(Use "Triggers" Activity – Discuss things that may relate to staffs own triggers and possible triggers of the individuals they serve)

Recognizing precursors

Precursors are behaviors which often precede challenging episodes. They may be an obvious prelude to distressed or aggressive behavior or they may just leave staff feeling uncomfortable. They may signpost the onset of challenging behavior. Staff needs to be aware of precursors and recognize them so they can effectively de-escalate a situation. Precursors to challenging behavior are specific to individuals, so they can often be recognized from earlier episodes.

(Retrieved from http://www.reducingdistress.co.uk/reducingdistress/wp-content/uploads/2014/02/Meeting_needs_and_reducing_distress.pdf)

(20) Staff will demonstrate competence in identifying how the behavior and actions of one's self and others may contribute to escalation of behavior. [27E .0107(g)(2)(7-9)]

The poor care, actions or inactions from staff can lead to abuses of people that they serve as well as contribute to the escalation of aggressive behaviors that can illustrate only too clearly what can go wrong when there are poor standards of care and a culture which allows it to happen. Inappropriate or inadequate actions from staff supporting

individuals can result in serious repercussions on the safety, wellbeing and dignity of the people they serve; staff that fail in their duty of care to the people they serve can put themselves at risk; and organizations that tolerate these poor practice fail to be accountable for delivering high quality care. When the delivery of care is sub-standard, this often exacerbates and perpetuates a person's distress, leaving staff increasingly unable to cope, and abusive practices can soon become the norm.

(Retrieved from http://www.reducingdistress.co.uk/reducingdistress/wp-content/uploads/2014/02/Meeting_needs_and_reducing_distress.pdf)

Staff attitudes and behavior

The way staff members treat others is so important. What you do and say can help people stay calm or can contribute to behavioral escalation and aggression. Examples of things that tend to escalate behavior:

- ignoring people
- expecting absolute obedience to your authority (authoritarian)
- *telling* rather than *asking*
- giving unnecessary commands
- acting superior to the people with disabilities (condescending)
- making decisions *for* the person instead of *with* the person
- behaving aggressively (yelling, speaking loudly, being "in-the-face", threatening, criticizing)
- teasing or picking — this may be OK with friends and family, but people with disabilities might not understand it or be hurt by it
- not following through — "don't make promises you can't keep"

- making unreasonable and unenforceable consequences
- interrupting something the person likes doing

(Retrieved from NCI Participant Workbooks (2003) – Prevention - Public Domain)

(21) Staff will demonstrate competence in identifying environmental factors that can contribute to the distress of staff and people with disabilities in a way that would compromise safety. [27E .0107(g)(3)(5)(7)]

Certain social and environmental factors can provoke challenging behavior, especially if they are prolonged or interfere with someone's routine or sleep, e.g.:

- noise
- bright lights
- uncomfortable temperatures
- overcrowding
- overstimulation
- inactivity and boredom.
- Additionally, a lack of understanding of an individual's culture and related behavior can lead to frustration and agitation.

(Lecavalier, Leaone and Witz (2006). The impact of behaviour problems on caregiver stress in young people with autism spectrum disorders. Journal of Intellectual Disability Research. Volume 50 Paert 3 pp 172-183)

(22) Staff will demonstrate competence in identifying internal factors that may contribute to the distress of staff and people with disabilities in a way that would compromise safety. [27E .0107(g)(3)(5)(7)]

The following are some internal factors that may contribute to the distress of staff and people with disabilities in a way that would compromise safety:

- the person's inability to process new information, explanations or instructions
- loss of inhibitions
- poor judgment and planning
- difficulty with communication and inability to articulate needs
- memory loss
- disorientation
- reduced spatial awareness
- loss of insight.

These may be for example:

- feelings of anxiety or powerlessness
- anger
- social isolation
- depression
- delusions, especially where people feel threatened and react defensively
- personality disorders which may cause difficulty anticipating the consequences of their actions and acute distress

- mania
- hallucinations
- suicidal tendencies.

(Retrieved from http://www.reducingdistress.co.uk/reducingdistress/wp-content/uploads/2014/02/Meeting_needs_and_reducing_distress.pdf)

(23) Staff will demonstrate competence in identifying verbal and non-verbal communication strategies and skills that can be used to calm to a person in distress. [27E .0107(g)(3)(5)(7)(8)(9)]

In crisis intervention, predisposition is somewhat different. It means predisposing individuals to be receptive to our intervention when, in many instances, they may not be at all enthused about our presence or be so out-of-control that they are only vaguely aware of us. Therefore, predisposition has a lot to do with the attitudinal set and predisposition of how staff enters the situation. A number of individuals that staff will work with will not act, talk, look, or even smell nice! The ability to convey empathy and be authentic as to who and what you are doing without pretense is critical, particularly if it is a first contact, Pre-dispositioning the individual as to what to expect is critical. Along with letting the person know what is going to occur, it is important to make contact in such a way that the person can see the interventionist as an immediate ally and support, and not another in a long line of people, representative of bureaucracies and institutional authorities, who have been anything but helpful in resolving their problems. One of the most critical initiating components of crisis intervention is how the staff initiates communication with the person to begin de-escalation.

Establishing Psychological Connection.

First and foremost, you need to introduce yourself in a way that is nonthreatening, helpful, and assumes a problem solving as opposed to an adversarial approach.

Clarifying Intentions.

Clarifying intentions means informing the person about what the crisis intervention process is and what the person can expect to happen. For many individuals who are in crisis, this may be the first time crisis intervention is needed, and may have little if any idea of what is going to happen or how it is going to happen.

Problem Exploration: Defining the Crisis

A major initial task in crisis intervention is to define and understand the problem from the individuals' point of view. Unless the worker perceives the crisis situation as the individual perceives it, all the intervention strategies and procedures the staff might use may miss the mark and be of no value to the individual. Intervention begin with staff practicing what are called the *core listening skills*: empathy, genuineness, and acceptance or positive regard.

Defining the crisis does mean attempting to identify the precipitating event across the affective, behavioral, and cognitive components of the crisis. This task serves two purposes. First, the interventionist sees the crisis from the individuals' perspective. Second, defining the crisis gives the interventionist information on the immediate conditions, parties, and issues that led to eruption of the problem into a crisis.

Psychological Support. First and most immediate is providing psychological and physical support. Deep, empathic responding using reflection of feelings and owning statements about the person's present condition serves as a bonding agent that says

emphatically, "I am with you right here." In Task 3, the person providing the support is the crisis worker. This means that workers must be able to accept, in an unconditional and positive way, all their persons, whether the persons can reciprocate or not. The worker who can truly provide support for persons in crisis is able to accept and value the person no one else is willing to accept.

Providing Support

The third task in crisis intervention emphasizes communicating to the individual that the staff is a person who cares about the individual. Staff cannot assume that an individual experiences feeling valued, prized, or cared for.

Default Task: Safety

Safety is a default task that is *always* operational. Safety is a primary consideration throughout crisis intervention for a variety of reasons that are both physically and psychologically based. The task of assessing and ensuring the person's and others' safety is always part of the process, whether it is overtly stated or not. When we speak of safety, we are concerned about the physical safety not only of the person but also of those who may interact with him or her and, just as important, about keeping ourselves safe. Whether by commission or omission, persons often put themselves in hazardous situations as a result of their affective, behavioral, and cognitive reactions to the crisis.

(James, R. & Gilliland, B. (2013), Crisis intervention strategies. Belmont, CA: Brooks/Cole)

(24) Staff will demonstrate competence in identifying ways to model and teach alternatives to potentially dangerous behavior. [27E .0107(g)(4)(7-9)]

Examining Alternatives

- Examining alternatives addresses an area that both persons and workers in crisis intervention often neglect—exploring a wide array of appropriate choices available to the person. In their immobile state, persons often do not adequately examine their best options. Some persons in crisis actually believe there are no options.
- Alternatives can be viewed from three perspectives: (1) *Situational supports* are people known to the person in the present or past who might care about what happens to the person. (2) *Coping mechanisms* are actions, behaviors, or environmental resources the person might use to help get through the present crisis. (3) *Positive and constructive thinking patterns* on the part of the person are ways of reframing that might substantially alter the person's view of the problem and lessen the person's level of stress and anxiety. The effective crisis worker may think about an infinite number of alternatives pertaining to the person's crisis but discuss only a few of them with the person. Persons experiencing crisis do not need a lot of choices; they need appropriate choices that are realistic for their situation. Some of these coping skills may be already present in the person but under the stress of the crisis may be forgotten or dismissed as ineffective because they were used "back when" or "back there" and are no longer workable in the here and now.
- Examining alternatives is literally a "right here, right now" activity. Rapidly changing conditions may mean discarding old options that worked a half hour ago for completely new ones. One of the hallmarks of a world class crisis worker

is the ability to be resilient and rapidly brainstorm new ideas and implement them in a hurry.

(James, R. & Gilliland, B. (2013), Crisis intervention strategies. Belmont, CA: Brooks/Cole)

(25) Staff will demonstrate competence in identifying ways to help a person manage distress. [27E .0107(g)(4)(7-9)]

Planning in Order to Reestablish Control

A hallmark of people in crisis is the feeling of the loss of control. Chaos reigns and every effort to manage the situation have failed. Reestablishing control means helping individuals create a plan to guide them in the resolution of the crisis. Such a plan needs to consider what options are available to the person and what choices need to be made in regard to those options. One of the primary strategies in planning to reestablish control is mobilizing the person. The fifth step in crisis intervention, making plans, flows logically and directly from Task 4 alternatives. Much of the material throughout this book focuses either directly or indirectly on the crisis worker's involvement with individuals in planning action steps that have a good chance of restoring the person's emotional, behavioral, and cognitive equilibrium. A plan should (1) identify additional persons, groups, and other referral resources that can be contacted for immediate support, and (2) provide coping mechanisms—something concrete and positive for the person to do now, definite action steps that the person can own and comprehend. The plan should focus on systematic problem solving for the person and be realistic in terms of the person's coping ability. While it may be that crisis workers have to be very directive at times, as much as possible it is important that planning be done in collaboration with

individuals so that individuals feel a sense of ownership of the plan. At the very least, explaining thoroughly what is about to occur and gaining person acquiescence is extremely important. The critical element in developing a plan is that individuals do not feel robbed of their power, independence, and self-respect. The central issues in planning are individuals' *control* and *autonomy.* The reasons for individuals to carry out plans are to restore their sense of control and to ensure that they do not become dependent on support persons such as the worker. It should be emphasized that planning is not what individuals are going to do for the rest of their lives. Planning is about getting through the short term and getting some semblance of equilibrium and stability restored. Most plans in crisis intervention are measured in minutes, hours, and days, not weeks, months, or years.

(James, R. & Gilliland, B. (2013), Crisis intervention strategies. Belmont, CA: Brooks/Cole)

(26) Staff will demonstrate competence in identifying the responsibilities, protocol, and strategies necessary to effectively and immediately intervene with a colleague when observing behavior that has the potential to trigger or escalate a person with disabilities' emotional distress. [27E .0107(g)(1-2)(4-5)(7-9)]

If you notice that a co-worker seems to be having difficulty with others, you can set up a "buddy system" to help. That is, volunteer to work alongside the other person and be a role model. If you see something getting out of hand, you must step in to stop it and get the co-worker out of the situation. You can try to preserve dignity by suggesting a coffee break or that the person is needed elsewhere. Even if the situation did not include actual aggression, it would be helpful for you to sit down

with the co-worker later to talk over what happened and how to avoid it in the future. In many cases, your supervisor needs to know what happened.

If you are a co-worker you have ethical and legal issues to think about in this situation as well as loyalty to your co-workers. Legally, you are required to report abusive behavior. You will need to follow the law and your agency's procedures. You have a responsibility to see that people with disabilities are treated with respect and without harm, and your agency will hold you accountable for that.

(Retrieved from NCI Participant Workbooks (2003) – Prevention - Public Domain)

Do what is necessary to protect the immediate safety of the person who is being abused. For example, stay in the room and do not leave an abusive person alone with the person. · If you have concerns about talking to an abusive person, do not do it. Trust your instincts. Confronting a violent or abusive person can be dangerous. Be aware of the risks and do not leave yourself open to harm. · Within your organization, report the abuse to someone who is in a higher position than the abusive person. · If the abuse involves fraud, theft or physical injury, report the abuse to police. · If the abuse happens in a care facility, such as a group home, day program, shelter, personal care home, lodge, hospital, nursing home or other continuing care facility, you are required to follow your agencies protocol to report the abuse. Anonymous reports are not accepted. · Write down what you have seen and heard, as well as what you have done about it. You may need to have a record of this information when the abuse is investigated. What is your agencies protocol?

(Retrieved from http://www.eldercarelink.com/Other-Resources/Caregiving-Support/danger-at-home-when-caregiver-stress-leads-to-abuse.htm)

(27) Staff will demonstrate competence in identifying the risk and protective factors that may affect a person's behavior. [27E .0107(g)(1-2)(5)(7)]

Risk and Protective Factors

Assessing the risk and protective factors that contribute to substance use disorders helps practitioner's select appropriate interventions.

Many factors influence a person's chance of developing a mental and/or substance use disorder. Effective prevention focuses on reducing those risk factors, and strengthening protective factors, that are most closely related to the problem being addressed. Applying the Strategic Prevention Framework (SPF) helps prevention professionals identify factors having the greatest impact on their target population.

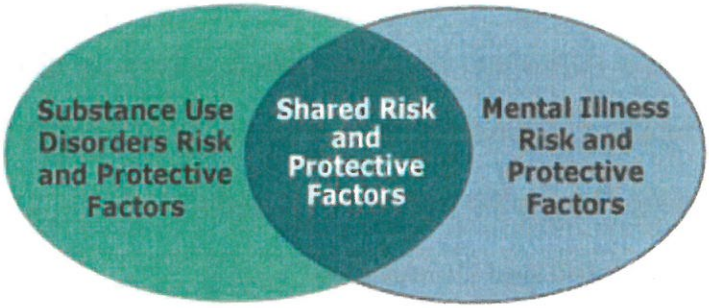
Risk factors are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes.

Protective factors are characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact. Protective factors may be seen as positive countering events.

Some risk and protective factors are fixed: they don't change over time. Other risk and protective factors are considered variable and can change over time. **Variable risk factors** include income level, peer group, adverse childhood experiences (ACEs), and employment status.

Individual-level risk factors may include a person's genetic predisposition to addiction or exposure to alcohol prenatally.

Individual-level protective factors might include positive self-image, self-control, or social competence.



Key Features of Risk and Protective Factors

Prevention professionals should consider these key features of risk and protective factors when designing and evaluating prevention interventions. Then, prioritize the risk and protective factors that most impact your community.

Risk and Protective Factors Exist in Multiple Contexts

All people have biological and psychological characteristics that make them vulnerable to, or resilient in the face of, potential behavioral health issues. Because people have relationships within their communities and larger society, each person's biological and psychological characteristics exist in multiple contexts. A variety of risk and protective factors operate within each of these contexts. These factors also influence one another. Targeting only one context when addressing a person's risk or protective factors is unlikely to be successful, because people don't exist in isolation. For example:

- **In relationships**, risk factors include parents who use drugs and alcohol or who suffer from mental illness, child abuse and maltreatment, and inadequate supervision. In this context, parental involvement is an example of a protective factor.

- **In communities**, risk factors include neighborhood poverty and violence. Here, protective factors could include the availability of faith-based resources and after-school activities.
- **In society**, risk factors can include norms and laws favorable to substance use, as well as racism and a lack of economic opportunity. Protective factors in this context would include hate crime laws or policies limiting the availability of alcohol.

Risk and Protective Factors Are Correlated and Cumulative

Risk factors tend to be positively correlated with one another and negatively correlated to protective factors. In other words, people with some risk factors have a greater chance of experiencing even more risk factors, and they are less likely to have protective factors.

Risk and protective factors also tend to have a cumulative effect on the development—or reduced development—of behavioral health issues. Young people with multiple risk factors have a greater likelihood of developing a condition that impacts their physical or mental health; young people with multiple protective factors are at a reduced risk.

These correlations underscore the importance of:

- Early intervention
- Interventions that target multiple, not single, factors

Individual Factors Can Be Associated With Multiple Outcomes

Though preventive interventions are often designed to produce a single outcome, both risk and protective factors can be associated with multiple outcomes. For example, negative life events are associated with substance use as well as anxiety, depression,

and other behavioral health issues. Prevention efforts targeting a set of risk or protective factors have the potential to produce positive effects in multiple areas.

Risk and Protective Factors Are Influential Over Time

Risk and protective factors can have influence throughout a person's entire lifespan. For example, risk factors such as poverty and family dysfunction can contribute to the development of mental and/or substance use disorders later in life. Risk and protective factors within one particular context—such as the family—may also influence or be influenced by factors in another context. Effective parenting has been shown to mediate the effects of multiple risk factors, including poverty, divorce, parental bereavement, and parental mental illness.

The more we understand how risk and protective factors interact, the better prepared we will be to develop appropriate interventions.

Universal, Selective, and Indicated Prevention Interventions

Not all people or populations are at the same risk of developing behavioral health problems. Prevention interventions are most effective when they are matched to their target population's level of risk. Prevention interventions fall into three broad categories:

- **Universal preventive interventions** take the broadest approach and are designed to reach entire groups or populations. Universal prevention interventions might target schools, whole communities, or workplaces.
- **Selective interventions** target biological, psychological, or social risk factors that are more prominent among high-risk groups than among the wider population. Examples include prevention education for immigrant families with young Individual's or peer support groups for adults with a family history of substance use disorders.

- **Indicated preventive interventions** target individuals who show signs of being at risk for a substance use disorder. These types of interventions include referral to support services for young adults who violate drug policies or screening and consultation for families of older adults admitted to hospitals with potential alcohol-related injuries.

(Retrieved from https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/risk-protective-factors)

(28) Staff will demonstrate competence in recognizing the importance of teaching appropriate and useful interpersonal, social, coping, and self-management skills (domains of thinking, doing, and feeling) [27E .0107(g)(1-2)(6)]

Teaching individuals appropriate and useful interpersonal, social, coping, and self-management skills (domains of thinking, doing, and feeling) comes with first getting individuals to be aware of who they are; what their belief systems (thoughts) is and how they affect feelings and behaviors:

Interpersonal Skills

Interpersonal skills are the life skills we use every day when we communicate and interact with other people, both individually and in groups. People who have worked on developing strong interpersonal skills are usually more successful in both their professional and personal lives

Self-Awareness: Human beings are complex and diverse. To become more self-aware, we should develop an understanding of ourselves in many areas. Key areas for self-awareness include:

- our personality traits (an understanding of our personalities can help us find situations in which we will thrive, and help us avoid situations in which we will experience too much stress);
- personal values (when we focus on our values or what is most important in your life, you are more likely to accomplish what you consider most important);
- habits (behaviors that we repeat routinely and often automatically);
- needs (a variety of psychological needs drive behaviors such as needs for esteem, affection, belongingness, achievement, self-actualization, power and control. One of the advantages of knowing which needs exert the strongest influence on our own behaviors is the ability to understand how they affect our interpersonal relationships) and;
- emotions (understanding your own feelings, what causes them, and how they impact your thoughts and actions is emotional self-awareness).

Communication Skills include:

- Verbal Communication – What we say and how we say it
- Non-Verbal Communication – What we communicate without words, body language is an example
- Listening Skills – How we interpret both the verbal and non-verbal messages sent by others

- Team-Working – Working with others in groups and teams, both formal and informal
- Negotiation, Persuasion and Influencing Skills – Working with others to find a mutually agreeable (Win/Win) outcome
- Conflict Resolution and Mediation – Working with others to resolve interpersonal conflict and disagreements in a positive way
- Problem Solving and Decision-Making – Working with others to identify, define and solve problems, which includes making decisions about the best course of action

(Retrieved from https://www.skillsyouneed.com/interpersonal-skills.html)

(29) Staff will demonstrate competence in identifying ways to help a person identify and engage in behavior and activities that are effective alternatives to unsafe behavior. [27E .0107(g)(1-2)(6)(8-9)]

How Should Staff Encourage Positive Behaviors? Knowing that behavior has a purpose and is affected by other factors, you can help the person you serve build the necessary skills to communicate more effectively. Here are some strategies to try.

1. Reinforce Good Behavior - Give praise for appropriate behavior. "Catch" them doing the right things.

2. Provide Structure and Consistency - Individuals need consistent schedules and ground rules. Such stability helps provide a safe and predictable environment for them to learn appropriate behaviors over time.

3. Collect Data - Keep a log that documents challenging behaviors. Note when the behavior occurs, what the person is doing before and after it happens, and what is going on in the environment when the behavior takes place. If you see a consistent pattern, then you can devise strategies to address that behavior.

4. Name the Behavior - You're Encouraging By naming the appropriate behavior for the person, you are helping him or her reinforce it.

5. Give Words for Emotions - Help your identify emotions and needs in certain situations by teaching simple phrases such as "I don't like that!" or "Help me!" Also use language to explain feelings and bring a conclusion to them. For example, you might teach him or her to say, "I'm all done being mad."

6. Change the Environment - If you can change the environment so a behavior is reduced or eliminated, it will help that person.

7. Give Choices - Give the person a sense of control by offering basic choices. To keep things simple, it's best to give only two options, such as, "Do you want to wear your blue shirt or yellow shirt?"

8. Avoid Power Struggles - Try to compromise. For example, you might say, "Let's clean together - I'll sweep the floor and you can make up the bed."

Positive Behavior Support (PBS) an empirically based model is a framework for developing effective interventions and programs for individuals who exhibit challenging behavior. PBS uses a wide variety of procedures and strategies drawn from applied behavior analysis, and as such involves the utilization of empirically tested assessments and interventions. The framework of PBS describes both (a) a set of values regarding

quality of life and the rights of persons with disabilities and (b) procedures and steps to be used when working with people who exhibit challenging behavior. PBS perspective generally are characterized by three features: (a) They operate from a person-centered values base, (b) they recognize the individuality of each person, and (c) they work toward and achieve meaningful outcomes

Dignity - Dignity generally refers to an individual's perception of his or her standing, based on interactions within their environment. We might say that one has dignity when perceiving his- or herself as being worthy and successful in an independent manner-or when a person has personal "confidence" or "self-esteem" within a social context. We recognize and reinforce a person's dignity when we create environments that facilitate individual success and allow that person to take credit for that success.

Independence - Personal dignity necessarily entails both success and freedom from constraint. But success creates and is created by a confidence that is dependent on real experiences of independent success rather than simple non-contingent praise. Thus, a positive circular relationship exists, involving the promotion of success, recognition of success, and resulting confidence.

Prevention - If prevention efforts are to respect the dignity of all involved, strategies must facilitate success while keeping all safe from constraint, embarrassment, and pain. Fostering independence requires stakeholders to have an active voice in identifying needs, developing plans, and evaluating effects to ensure that the interdependent balance between the environment and behavior is as equal as possible while still reasonably predicting success. Again, the acceptability of any imbalance is an issue of social validity that must be determined by the stakeholders themselves. Pre-correction,

reminders, visual prompts, clear routines, and well-considered physical layouts must be used to increase the probability of success

(Scott, T. M. (2007). Issues of personal dignity and social validity in schoolwide systems of positive behavior support. Journal of Positive Behavior Interventions, 9(2), 102-112. Retrieved from https://library.capella.edu/login?url=http://search.proquest.com.library.capella.edu/docview/218791161?accountid=27965)

(30) Staff will demonstrate competence in identifying ways to help a person identify and develop strategies and resources to accomplish alternatives to unsafe behavior. [27E .0107(g)(1-2)(4)(6)(8-9)

Informational Support: At other times, persons do not have adequate information to make good decisions. The need for informational support is particularly critical in examining alternatives. One of the best techniques staff can be in command of is the ability to provide information on where, how, who, and what resources persons can access to get out of the predicament they are in.

(James, R. & Gilliland, B. (2013), Crisis intervention strategies. Belmont, CA: Brooks/Cole)

PART I UNIT FIVE
DEESCALATING ESCALATING BEHAVIORS

Key Points

1. Communication skills and Active Listening skills are used to prevent escalating aggressive behavior and to assist the person with de-escalating aggressive behavior
2. What you say can help deescalate aggressive behavior such as: Use a low tone of voice; Give reassurance; Use "I" messages; Ask what, when, how questions; Be clear up front about any rules in the situation and; Let the other person do most of the talking - ask questions to clarify if needed
3. How you say it or your body language can help deescalate aggressive behavior such as: Use a non-threatening body stance - relaxed, arms down at side and not crossed or on hips and hands open and giving the person space standing a minimum of one and a half to two feet away from the person escalating
4. Before staff attempts to physically intervene or diffuse a situation where a person behavior is escalating they must first determine intent and capacity to do harm by asking themselves the following questions: 1) Does this person have a history of hitting, biting, running away, etc?; 2) What is this person's crisis plan?; 3) What is

my agency's policy regarding this type of intervention? And; 4) before I have to put my hands on, is there anything else that might be done to resolve this crisis appropriately without using physical intervention?

5. **An individual's problematic or inappropriate behavior is a sign that he is upset and that something is not right. Individual's sometimes have trouble communicating, because they may not be able to verbally describe the problem or know what to do in a situation. At these times, Individual's may act out their feelings or needs.**
6. **It is important that staff read the charts and records of individuals especially their crisis plans. This information will assist staff with identifying the triggers that set off diagnostic and behavioral symptoms in the person that they serve. As usual getting to know and understand the person is usually the most effective way to identify triggers that set off increased emotional distress that leads to inappropriate or negative behavior.**

Training in Seclusion, Physical Restraints and Isolation Time-Out Restrictive Intervention Competencies

(1) Staff will demonstrate competence in Identifying strategies that can be used for prevention and early intervention during behavioral escalation. [27E .0108 (g)(1)(4)]

There are times when through no apparent reason a person's behavior can begin to escalate or begin to deteriorate. Staff's goal is to avoid an escalation and to avoid a confrontation. Begin to

attempt strategies focused on assisting the person to cool off and calm down. It is at this time that staff should begin thinking of what skills and strategies to use that would work in the person to gracefully back out of the situation and exit. The person saving face can be very important to someone who feels he/she hasn't got much else.

Communication skills

The Communication skills and Active Listening skills that were practiced earlier are taken up a notch when we are using those skills to prevent escalating aggressive behavior and to assist the person with de-escalating aggressive behavior.

What you say

- Use a low tone of voice — it is calming, and the other person will have to be quiet to hear you
- Give reassurance — tell the person that you are not there to hurt him/her but want to help him/her to get what's wanted if possible. Ask how you can help.
- Use "I" messages
- Ask what, when, how questions - Getting the facts is usually seen as a good thing. However, it can shut down the other person. (Think about this interaction with a teenager: "Where were you?" "Out" "What were you doing?" "Nothing.") Don't, ask why. In the first place, asking why can be seen as threatening. In the second place, a lot of the time, people really don't know why they are doing what they're doing. You can work on the "why" later.
- Be clear up front about any rules in the situation — such as that you cannot let them hurt themselves or anyone else, how much time you can stay with the person and/or that you can't promise not to tell others

- Let the other person do most of the talking - ask questions to clarify if needed.

At the end of the encounter - summarize what each of you has agreed to do and what information will be shared. Say something positive. ("You seem to be calmer now." "Thanks for talking with me." "You did a good job of thinking this through.")

Body language or "how you say it"

- Use a non-threatening body stance - relaxed, arms down at side and not crossed or on hips and hands open.
- Give the person space. Keep about $1^1/_2$ -2 feet away or more if the person is escalating.

Touch the person only if you have to. If you must touch them, tell the person what you are going to do.

(Retrieved from NCI Participant Workbooks (2003) – Prevention - Public Domain)

(Use "Let's Do an Exercise" Role Play Activity – Discuss feelings of participants and get class feedback on how the de-escalation went)

(2) Staff will demonstrate competence in describing methods for assessing whether to attempt to diffuse the situation or to intervene physically. [27E .0108 (g)(1-3)]

To make an educated on the spot assessment of whether to try to diffuse the situation staff must ask themselves several questions such as:

- Can I handle this situation alone?
- Is there potential for danger for others?
- Is help readily available?
- Can I keep from getting angry?
- Is my appearance going to interfere with my ability to respond?

- Can I get others to a safe exit, if necessary?

(Retrieved from NCI Participant Workbooks (2003) – Prevention - Public Domain)

(3) Staff will demonstrate competence in recognizing and assessing signs of intent and capacity to harm. [27E .0108 (g)(2)]

Once staff surveys the immediate area and environment for obstacles and or impediments to make the area safe for the person and others in case they would need to attempt to diffuse or physically intervene there needs to be follow up questions to determine the persons intent and capacity to harm

- Does this person have a history of hitting, biting, running away, etc?
- What is this person's crisis plan?
- What is my agency's policy regarding this type of intervention?
- Before I have to put my hands on, is there anything else that might be done to resolve this crisis appropriately without using physical intervention?

(Retrieved from NCI Participant Workbooks (2003) – Prevention - Public Domain)

(4) Staff will demonstrate competence in recognizing signals for imminent danger of injury to self and others. [27E .0108 (g)(2)]

There are early warning signs in most cases of violence to self and others, certain behavioral and emotional signs that, when viewed in context, can signal a troubled individual. Early warning signs are a signal that the person needs help—now!

Psychologists emphasize several important principles to observe when early warning signs appear evident:

(1) *do no harm*—early warning signs should not be used as a rationale to exclude, isolate, or punish a person;

(2) *understand violence and aggression within a context*—there may be many antecedent factors, in the home and/or school, for persons at risk of committing violent acts;

(3) *avoid stereotypes*—it is important to be aware of false cues, including race, socioeconomic status, learning difficulties, or physical appearance;

(4) *view warning signs within a developmental context*—know what is developmentally appropriate behavior so that supposed warning signs are not misinterpreted;

(5)*understand that persons typically exhibit multiple warning signs*—research confirms that most persons at risk of aggression exhibit more than one warning sign repeatedly and with increasing intensity over time.

Signals for Imminent Danger

A good rule of thumb is to assume that warning signs, especially when exhibited in combination, indicate a need for further analysis to determine an appropriate intervention for the person.

- *Social withdrawal.* Withdrawal often stems from feelings of depression, rejection, persecution, unworthiness, and lack of confidence.
- *Excessive feelings of isolation.* The majority of persons who appear isolated or friendless are *not* violent and may be in need of other types of specialized help. However, research also shows that such feelings can be associated with violent behavior and should not be ignored.
- *Excessive feelings of rejection.* Some aggressive persons who are rejected by non-aggressive peers may seek out aggressive friends who, in turn, reinforce violent tendencies.
- *Being a victim of violence.* Research shows that persons who have been victimized by others are sometimes at risk of becoming violent toward themselves or others.

- *Feelings of being picked on or persecuted.* Persons who feel constantly teased, bullied, singled out for ridicule, or humiliated at home or school may, if not given adequate support, vent their emotions in possible aggressive behavior.
- *Low school interest and poor academic performance.* In some situations, such as those in which the low-achiever feels frustrated, unworthy, chastised, and denigrated at home or at school, acting out behavior in aggressive ways may occur. It is important to assess the emotional and cognitive reasons behind poor performance in school to determine the true nature of the problem.
- *Expression of violence in writings and drawings.* Many persons express themselves through drawings, stories, diaries, journals, poetry, and other expressive forms. Most are essentially harmless. However, an overrepresentation of violence that is focused on depictions of family members, peers, teachers, administrators, or others consistently over time may signal emotional problems and potential violence.
- *Uncontrolled anger.* Everyone gets angry. It's a basic human emotion. However, anger that is expressed frequently and intensely in response to minor irritants may signal potential violent behavior toward self or others.
- *Patterns of impulsive and chronic hitting, intimidating, and bullying behavior.* Persons often engage in acts of shoving and mild aggression. However, some mildly aggressive behaviors, such as constant hitting or bullying of others, if left unattended, may escalate into more serious problems.
- *History of discipline problems.* Persons with a history of chronic behavior problems both in school and at home indicate unmet needs. These problems may set the stage for more

deliberate violations of norms and rules, defiance of authority, disengagement from school, and involvement in aggressive behavior directed toward peers and adults.

- *Past history of violent and aggressive behavior.* Unless provided with emotional support and professional help, persons who have previously committed violent or aggressive acts are at significant risk of repeating such behavior. Prior aggressive behavior may have been directed at persons or expressed through cruelty to animals, fire setting, lying, vandalism, or other antisocial acts. *Research suggests that age of onset may be a key factor in interpreting early warning signs. Persons who engage in aggression and drug abuse at an early age—before age twelve—are more likely to show violence later on than are persons who begin such behavior at a later age.* In the presence of such signs it is important to review the person's history with behavioral experts and to seek parents' observations and insights in planning help.
- *Drug and alcohol use.* Apart from being unhealthy behaviors, drug use and alcohol use reduce self-control and expose persons to violence . . . as perpetrators, as victims, or both.
- *Affiliation with gangs.* Gangs that support antisocial values and behaviors, including extortion, intimidation, and acts of violence toward other persons, cause fear and stress among other persons. Youth who are influenced by gangs, who emulate their behavior and values, as well as those who actually join a gang, may act in violent and aggressive ways in certain situations. Gang-related violence and turf battles are common occurrences in some communities and often lead to injury and death, frequently including innocent victims.
- *Inappropriate access to, possession of, and use of firearms.* Families can reduce inappropriate access to and use of firearms by their children through careful monitoring and supervision. Persons with a history of aggressive, impulsive, or other emotional problems should not have access to firearms or other weapons.

- *Serious threats of violence.* Idle threats are a common response to frustration. *Alternatively, one of the most reliable indicators that a person is about to commit a violent act toward self or others is a detailed, specific threat to use violence.* Such threats must always be taken with utmost seriousness. Steps must be taken to understand and address the reasons for the threats and to prevent them from being carried out.

(Retrieved from http://pubs.cde.ca.gov/tcsii/documentlibrary/earlywarningsigns.aspx)

(5) Staff will demonstrate competence in assessing what the behavior is communicating. [27E .0108 (g)(2)(5)]

Everybody communicates through behavior. An infant may cry when she is hungry or wet, just like an adult may yawn when he is bored at work. People are communicating something through their behavior during every moment in every day, even if they are not aware of it. An individual's problematic or inappropriate behavior is a sign that he is upset and that something is not right. Individual's sometimes have trouble communicating, because they may not be able to verbally describe the problem or know what to do in a situation. At these times, Individual's may act out their feelings or needs. Individuals engage in challenging behavior for a reason. The purpose may be getting someone's attention, stopping an activity they don't like, or satisfying sensory needs — but there is always a reason behind the behavior. Individuals with challenging behavior are sending staff the message that something is not right or that their needs are not being met. There could be many reasons for a single behavior, such as being hungry, scared, hurt, tired, bored, sad or angry. Some Individual's may engage in behavior that seems destructive, because they

enjoy the physical sensation (for example pulling threads from clothing). Sometimes Individual's feel unsafe or out of control, so they take inappropriate action over the things they do control, like being able to kick someone. A person who has tried several times to communicate to staff about what they needs, but whose needs remain unmet, will often use problem behavior as a way of sending a very loud message.

Since Individual's often use their behavior to tell us what they need, adults can help the child by figuring out the meaning behind the child's behavior. All Individual's, but especially those who display challenging behavior, need the consistency of a reliable and caring adult who will provide support and guidance, especially during difficult times.

(Retrieved from

http://www.pbs.org/parents/inclusivecommunities/challenging_behavior2.html)

(6) Staff will demonstrate competence in recognizing triggers and indicators of increased emotional distress. [27E .0108 (g)(1-2)]

In the strictest sense of the term, trigger is used to refer to experiences that "re-trigger" trauma in the form of flashbacks or overwhelming feelings of sadness, anxiety, or panic. The brain forms a connection between a trigger and the feelings with which it is associated, and some triggers are quite innocuous. The term is used more loosely to refer to stimuli that trigger upsetting feelings or problematic behaviors, and these feelings are often associated with a psychiatric condition. People who have triggers may re-engage in unhealthy behaviors when exposed to triggers. It is impossible to predict or avoid all triggers because so many triggers are innocuous, but images of violence, substance abuse, or weapons are sometimes labeled with a trigger warning. The exact brain

functioning behind triggers is not fully understood. However, there are several theories about how triggers work. Sensory memory can be extremely powerful, and sensory experiences associated with a traumatic event may be linked in the memory to this event, causing an emotional reaction even before a person realizes why he or she is upset. Habit formation also plays a strong role in triggering. People tend to do the same things in the same way.

It is important that staff read the charts and records of individuals especially their crisis plans. This information will assist staff with identifying the triggers that set off diagnostic and behavioral symptoms in the person that they serve. As usual getting to know and understand the person is usually the most effective way to identify triggers that set off increased emotional distress that leads to inappropriate or negative behavior.

(Retrieved from http://www.goodtherapy.org/blog/psychpedia/trigger)

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Evidenced Based Protective Interventions

EBPI

Participant Workbook

Base Physical Techniques

July 2017

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PART II

RESTRICTIVE INTERVENTION COMPETENCIES

(7) Staff will demonstrate competence in defining and describing the concepts of least restrictive interventions and the incremental steps in an intervention. [27E .0108 (g)(1-2)]

In the past restraint has been used, "to inflict pain, humiliate or punish". There surely can be no greater condemnation of an organizational culture than that it allows restraint to be used as a form of punishment. Interventions tend to take place in residential care homes or similar settings that are far removed from the public gaze.

The underlying philosophy of this guidance is that physical interventions should be used as a last resort. There is recognition that restrictive interventions will have to be used in some circumstances but their use must be "transparent, legal and ethical". Restrictive interventions are defined as follows:

- Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently.

There needs to be a strong policy lead at the organizational level if progress is to be made. Effective leadership is one factor alongside the involvement of people who use services, their families and advocates. Such actions are needed to take control of a dangerous situation or to reduce the danger to others. It is important that the process and steps be as follows:

- such actions and the limiting of a person's freedom should only be in place for as long as is necessary.

- If such restrictions are not imposed without there being a clear ethical framework and proper safeguards, then as the guidance makes clear such acts may be unlawful.
- When restrictive interventions are used there needs to be proper recording and data collection alongside appropriate post-incident reviews and staff training.

https://www.nationalelfservice.net/publication-types/guideline/department-of-health-publish-new-guidance-on-reducing-the-need-for-restrictive-interventions/

(8) Staff will demonstrate competence in describing protections in both law and rules. [27E .0108 (g)(1-8)]

Laws

North Carolina laws about alternatives to and the use of restraint and seclusion are found in: General Statutes 122C-51; 122C-53; 122C-59; 122C-60; 122C-62; 131E-67; and 143B-147.

Current statutes can be viewed online at:

http://www.ncleg.net/gascripts/statutes/statutestoc.pl

Rules

Approved rules for implementing the above referenced general statutes for both community facilities and state facilities are found in North Carolina Administrative Codes as follows: