ALABAMA DEPARTMENT OF HUMAN RESOURCES SOCIAL SERVICES DIVISION ADMINISTRATIVE CODE

CHAPTER 660-5-49
BEHAVIOR MANAGEMENT

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660-5-49-.01 Legal Authority.

Behavior Management policy has been developed to comply with the operating principles or Standards of the R. C. Consent Decree with particular emphasis on principal VIII, 55. This Consent Decree is a part of a federal lawsuit settlement known as R.C. v. Fuller case (R.C. v. Hornsby, No. 88-H-1170-N, Consent Decree) (M.D. Ala. Approved December 18, 1991).
Author: Jerome Webb
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660-5-49-.02 Introduction.

(1) **Purpose** - This policy is designed to serve several functions for children, their families, DHR and provider staff when behavior management interventions are deemed necessary for children to manage existing or learn new behaviors. These functions are the identification of general guidelines for behavior management interventions; a description of interventions which may be utilized when helping children manage existing or learn new behaviors; the identification of prohibited interventions; and the provision of guidelines and procedures for managing behaviors through the development of behavior management plans which use interventions that are in accordance with generally accepted professional standards. Provider responsibilities for behavior management are included in this policy as guidelines to follow when serving DHR children.

(2) **Glossary**: Various terms used in this policy are described below:

(a) **Advocacy** - The promotion of governmental and agency responsiveness to individual and class needs.

(b) **Age-Appropriate Child** - A child age 10 and older (except a child with severe mental retardation) or a child under age 10 who is intellectually capable of understanding and communicating ideas and opinions concerning the subject matter being discussed or considered.

(c) **Antecedent** - An event or any series of events ("reasons," "causes," or "prior learning") that contributes to a behavior's occurrence or frequency.

(d) **Behavior Management** - Treatment interventions that teach or increase the frequency of desirable behaviors and/or modify or extinguish undesirable behaviors by using reinforcers and/ or punishments or altering or controlling the environment and other events or conditioners affecting behavior.

(e) **Child and Family Planning Team** - The individuals involved in the planning and/or delivery of services for a child and family.

(f) **Consequences** - An event following a behavior which is used in managing the behavior and teaching self-regulation.

(g) **Crisis** - A situation where seclusion, restraint, or medication is used to protect children from a behavior which could seriously harm the child, harm others or cause substantial property damage and an appropriate Qualified Child Care Professional (QCCP) is not available to examine the child and assess the child's physical and psychological condition.

(h) **Crisis Plan** - A plan developed in partnership with the age-appropriate child and the family to protect the child in the event a behavior is displayed which could harm the child, harm others or cause substantial property damage.

(i) **Discipline** - The process of teaching a child healthy behaviors by responding to the behaviors in a manner that develops and promotes self-control and self-esteem.

(j) **Isolation** - The physical placement of a child in an unlocked room for a time-1imited period including isolation of a child in an unlocked room other than the child's own room; isolation of a child age 10 or over in his or her own room for more than two hours; isolation of a child under age 10 in his or her own room for more than one hour; and repeated confinement of a child in his or her room or any other room

(including time-out) that subjects the child to lengthy social isolation.

(k) **Medication** – Drugs prescribed for their effect on mood thought or behavior excluding non-psychotropic drugs such as those prescribed for physical conditions (e.g., antibiotics, insulin).

(l) **Provider** – Any individual, agency, or organization that utilizes behavior management interventions while serving children in the custody and/or planning responsibility or the Department of Human Resources.

(m) **Punishment** – Taking away something desirable or adding something undesirable to cause a decrease in the occurrence of a behavior.

(n) **Qualified Child Care Professional (QCCP)** – the following individuals may serve as QCCPs:

1. A licensed medical doctor with three years residence training in psychiatry;

2. A physician licensed to practice in the state of Alabama, with either specialized training or one year's experience in working with children in out-of-home placements;

3. A psychologist with a doctoral or master's degree from an accredited program who has either specialized training or one year's experience in working with children in out-of-home placements;

4. A social worker or professional counselor with a master's degree from an accredited program (and licensed in the state of Alabama) who has either specialized training or one year's experience in working with children in out-of-home placements;

5. A registered nurse with (a) a graduate degree in psychiatric nursing, (b) a concentration in pediatric nursing or (c) one year's experience in working with children in out-of-home placements; or

6. A child care professional with a graduate degree in child development or human development who has either specialized training or one year's experience in working with children in out-of-home placements.

(o) **Reinforcer** – A response, such as praise or a tangible reward, that strengthens a desired behavior. Reinforcers can also involve taking away something undesirable (i.e. room

restriction) to increase the likelihood of appropriate behavior.

(p) **Restraint** – Limiting or restricting a child's freedom of movement or use of the limbs. It includes Mechanical Restraint which is restricting a child's freedom of movement or use of limbs or body by applying devices such as cuffs, ties, nets, tubes, bags, straps, head gear, etc.; and Physical Restraint which is restricting a child's freedom of movement by physically holding the child for an extended period of time or repeatedly over time.

(q) **Reward** – A response given to acknowledge and support desired behavior.

(r) **Safety** – The condition or state of being free and/or secure from reasonable or foreseeable harm, danger, or injury.

(s) **Seclusion** – The isolation of a child in a locked seclusion room, a locked time-out-room, or any other locked room or place of confinement.

(3) **Children Covered by Policy** – This policy applies to all children in the custody and/or planning responsibility of the Department. Providers using behavior management interventions must follow these policies when designing and implementing behavior management plans for children in the custody and/or planning responsibility of DHR.

(4) **Disagreements and Grievances** – Disagreements and grievances about the type of behavior management interventions being used will be addressed in a fair, timely, and impartial manner by DHR and providers. Procedures for conflict resolution shall be established by the appropriate provider or provider agency. The parent(s) and age-appropriate child will be informed of these procedures in a manner understandable to them. The Department of Human Resources shall make age-appropriate children and their parents aware, in an effective manner, of the availability of advocacy and appropriate support services to assist them in pursuing a grievance in case of a disagreement.

(a) The parent(s) or age-appropriate child may request the child be discharged from the provider's program if the conflict cannot be resolved. Likewise, the provider can withdraw services or discharge the child from placement. However, the provider or DHR, whichever is appropriate, must give sufficient (i.e., as soon as possible, but not less than 30 days) **written** advance notice of the intent to withdraw services or discharge the child from placement in order to permit the child and family planning team to plan and provide appropriate alternative services or placement. Sufficient written advance notice may be waived only pursuant to the

decision of the child and family planning team when the ISP is reviewed prior to the decision to move the child.

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660-5-49-.03 Behavior Management Interventions.

(1) **Behavior Management Interventions** - Interventions used to manage children's behaviors and must be authorized by the child and family planning team and documented in the individualized service plan. The most normalized least restrictive interventions must be used to manage behaviors before the more restrictive interventions are pursued.

(a) **General Guidelines.**

1. General guidelines which apply to all behavior management interventions utilized by residential and non-residential providers, including foster family home, to manage children's behaviors include:

(i) Interventions shall be based upon the needs of each individual child and supportive of the child's permanency goal as stated in the family's individualized service plan;

(ii) Decisions regarding the use of specific interventions must be based upon an assessment that considers, among other things, whether the safety of the child and others can be adequately met by the proposed interventions, and the behavior is being managed with the minimum physical and psychological risk to the child and others;

(iii) The parent(s) or other legally responsible person/ agency and the age-appropriate child shall be informed of the purpose and benefits as well as the potential risk involved in behavior management interventions that will be used with a child;

(iv) Behavior management interventions must be administered in a manner which assists in establishing safety and emotional well-being for the child, offers ways for the child to gain control and have needs met without risk to personal safety or the safety of others, and demonstrates respect for the child as a person of worth and value;

(v) The child's behavior must be managed in a way that promotes the child's personal growth and assists in the development of a positive self-concept;

(vi) Interventions which stress the use of praise, supportive feedback and rewards shall be the principle methods used, and these interventions must be managed in a way that encourages and leads to self-regulation by the child;

(vii) The role of managing a child's behavior may be delegated to another child only when participating in an organized program of self-government which conforms to these standards and which is properly supervised by group home or residential staff;

(viii) Medication is to be used only when needed to assist children in gaining control of their behavior and if medically indicated by a qualified physician as a method of therapeutic treatment and only as prescribed by the physician on the prescription;

(ix) Seclusion and restraint are to be used only when alternative interventions have been unsuccessful or would not be practicable, and when needed to protect children from seriously harming themselves or others, including other children, staff, and family members, or needed to prevent substantial property damage;

(x) The DHR worker, caregiver or others, as identified by the child and family planning team, will provide supportive services necessary to implement interventions in the least restrictive environment for the child; and

(xi) Disagreements and grievances about the type of interventions being used will be addressed in a fair, timely, and impartial manner by both DHR and provider staff.

(2) **Prohibited Interventions** - Interventions that infringe upon the rights of the child and family and that do not consider the child's individualized treatment needs are prohibited. Medication, seclusion, and restraint shall not be used as retaliation or punishment, for the convenience of providers and their staff or as a substitute for more appropriate and less restrictive interventions or because of inadequate staffing. The most normalized, least restrictive measures for controlling children's behavior must first be implemented before pursuing more restrictive measures.

(a) Prohibited interventions include, but are not limited to:

1. Interventions that deny the child the right to humane care and protection from danger including abusive and neglectful actions of others and actions that prolong physical discomfort. Physical/corporal punishment, verbal abuse, threats or derogatory remarks about the child or the child's family must not be used;

2. Interventions that conflict with Department of Human Resources policies regarding telephone/mail access and visiting;

3. Interventions that withhold the basic necessities from a child (i.e., food, water, exercise, acceptable social interaction and age-appropriate activities);

4. Interventions that allow a child's peers to carry out discipline and/or fail to provide the child with proper adult supervision and guidance;

5. Interventions that deny the child opportunities for dignity, personal privacy and to live in a normalized environment;

6. Interventions that are of a vindictive nature and/or used for retaliation;

7. Interventions that are clearly not age-appropriate or are inappropriate for the child's abilities;

8. The use of medication, seclusion or restraint when the intervention **has not been authorized** by the child and family planning team in the individualized service plan; more appropriate or less restrictive interventions have not been tried; and the intervention is used in a manner that is not in accordance with this policy.

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660-5-49-.04 Restrictive Interventions.

(1) **Restrictive Interventions** - The more restrictive interventions for managing existing and teaching new behaviors include isolation, medication, seclusion, and restraint.

(a) Isolation - Isolation, a less restrictive intervention than medication, seclusion or restraint, is designed to be used with less extreme or dangerous behaviors than those

requiring seclusion or restraint. Isolation shall be used only when therapeutically indicated and as part of a behavior management plan to modify or eliminate targeted behaviors; used in conjunction with supportive and interactive treatment methods as the principle interventions; conducted in a manner that fosters the child's capacity for self-regulation; and time-1imited as specified in the behavior management plan with the child being released as indicated by the plan.

1. When a child is isolated, provisions shall be made for humane and safe conditions including room space appropriate to the developmental level of the child, adequate ventilation and lighting, and a room temperature consistent with the rest of the home or facility. Meals, routine medication and water must be provided. Observation of a child in isolation shall occur **at least every 30 minutes** or more often as necessary. The behavior management plan will describe how frequently the child must be observed and will authorize any restrictions imposed while the child is in isolation.

2. The use of isolation must be authorized in advance by the child and family planning team in accordance with the ISP and behavior management plan. Appropriate members of the child and family planning team (e.g., mental health professional, DHR worker, residential provider) shall explain and assist the age-appropriate child and family to understand the need for this intervention. The individuals designated to implement and monitor isolation will review the intervention frequently (e.g., weekly, bimonthly, monthly depending upon the frequency of usage) to determine if it is having the desired effect on the child, and if the desired outcome is not being achieved, isolation must be modified or discontinued.

3. The use of isolation 3 times or more in a 24 hour period or for more than 2 hours in a 24 hour period will be reviewed by the provider's treatment team for the intervention's appropriateness and the need for alternative interventions.

(b) **Medication, Seclusion and Restraint** - Medication, seclusion, and restraint are the more restrictive interventions for managing children's behaviors and **shall be used only** when approved by the child and family planning team to do so and when more normalized, less restrictive interventions have been unsuccessful or would not be practicable.

1. Medication may only be administered to children when the informed consent of the parent, legal custodian/ guardian, or the foster parent legally authorized to provide consent and the informed consent of the child

(age 14 or older) has been obtained. The child's and parent's preferences and requests for alternative interventions should be considered; and consent may be withdrawn at any time; however, a child's refusal to consent may be overridden by a court of appropriate jurisdiction.

2. Prescriptions for medication must be made by a licensed physician who is trained in the use of medication with children and adolescents. Medication is to be carefully and closely monitored by the child's physician and the child and family planning team for both desired effects and potential side effects.

3. A qualified physician must complete a thorough assessment of the child before prescribing medication in order to determine the appropriateness of prescribing the medication and to establish baseline data for monitoring its effects.

4. In a crisis where the child will seriously harm self, harm others, or cause substantial property damage, medication may be administered without informed consent upon an order by the treating physician and in accordance with generally accepted medical standards. There must be documented evidence in the child's record that in the physician's professional judgment, the harm or substantial property damage will occur without the benefit of the medication and that less restrictive interventions are not therapeutically indicated.

5. If it appears that medication will be used to address crises in a periodic, on-going pattern with the child, a court order or informed consent must be obtained from the child (age 14 or older) and the parent(s), legal custodian, guardian or foster parent legally authorized to provide consent.

6. The dispensing of Prescribed as Needed (PRN) medication can only be allowed if in compliance with a physician's approved protocol and the order is documented in the child's medical file of the provider's record and the child's DHR case record. PRN medications administered to address a child's behavior two or more times a week for three consecutive weeks will result in a comprehensive review of the child's individualized service and behavior management plans and the incidents, factors, and rationales for such PRN medication use.

(c) **Seclusion or Restraint** - Seclusion and restraint are two of the most restrictive interventions and shall be used only by those providers who meet the following criteria and who have been approved by DHR to utilize the interventions.

Seclusion or restraint may be used **only** as part of a behavior management plan approved by the child and family planning team and when more normalized, less restrictive interventions have been unsuccessful or would not be practicable.

1. Seclusion or restraint may be used only when needed to protect a child from seriously harming self or others (including other children, family members, and provider staff), or to prevent substantial property damage. Mechanical restraint may be used only when needed to protect the child from engaging in behavior that has a likelihood of resulting in serious self-injury.

2. The criteria for use of seclusion or restraint by residential treatment providers are when the provider has an on-site or on-staff QCCP at the time of the seclusion or restraint; the staff member(s) who will implement seclusion or restraint has received training from a qualified source to safely use the intervention(s); the provider's behavior management policy provides for adequate documentation of the use of seclusion or restraint; the provider has internal reporting and review procedures that include reporting all use of seclusion or restraint to the program's director and documenting all use of seclusion or restraint in a central file; a periodic review of seclusion or restraint practices will be done by a committee convened by the provider that includes outside persons; and the rooms or spaces used to seclude or restrain the child meet generally accepted professional standards.

3. If seclusion or restraint is authorized, there must be evidence in the provider's record for the child and the child's case record that the intervention is the most effective and least restrictive for managing behavior. The use of seclusion or restraint must be discontinued as soon as the child is no longer a danger and in accordance with the release criteria outlined in the QCCP's authorization/order.

4. The provider using seclusion or restraint and the child and family planning team shall monitor use of the intervention to determine if it is having a positive effect on the child and whether more normalized, less restrictive interventions could be used. **The use of seclusion or restraint 3 times or more in a 24 hour period or for more than 2 hours in a 24 hour period will be reviewed by the provider's treatment team and the program director for the intervention's appropriateness and the need for alternative interventions.**

(d) **Physical Environment And Care Of The Child** - The room or space used for seclusion or restraint is to be constructed to

protect the health, safety and well being of children placed there. The floor space will be appropriate to the developmental level of the child, the purpose of the seclusion or restraint and the maximum time a child might spend in the room. The design, construction and operation of any room or space used for seclusion or restraint are to conform to all applicable provisions of the Life Safety Code prescribed by the National Fire Prevention Association.

1. When a child is being restrained or secluded periodic observation of the child shall occur at least every 15 minutes, or more often as necessary, as well as verbal interaction with the child when appropriate; the child's physical and psychological condition shall be documented every 15 minutes or more frequently if indicated or ordered and vital signs must be taken as clinically indicated; the child shall not be deprived of food, fluids, toilet and bathing opportunities, and appropriate exercise; the child shall be protected from other children and environmental hazards; the child shall be protected from potential risks of self-injury; and care must be taken so that mechanical restraint does not restrict the flow of blood to the limbs, and protective devices are kept clean at all times.

(e) **Notification Of Parent, Legal Guardian/Custodian, DHR** - A child's parent, legal guardian/custodian, and the DHR worker shall routinely receive information about any use of seclusion or restraint with the child. The parent or legal guardian/ custodian and the DHR worker shall be notified, within the next 24 hours, if the child is placed in seclusion or restraint 3 times or more in a 24 hour period or for more than 2 hours in a 24 hour period.

(f) **Procedural Requirements** - Providers must follow the procedures below when authorizing and implementing seclusion or restraint.

1. **Authorization/Orders**.

(i) Prior to authorization and implementation, children shall receive a physical evaluation to identify any medical restrictions or prohibitions associated with the use of restraints or seclusion.

(ii) Each use of seclusion or restraint must be authorized by a written order from a QCCP who is physically present and has assessed the child's physical and psychological condition.

(I) **Exceptions** - AQCCP's authorization/order is not required for the brief use of seclusion (i.e., fifteen minutes or less) or the brief use

of restraint (i.e., five minutes or less) for the purpose of interrupting aggressive or assaultive behaviors or disruption to the therapeutic environment.

(II) In a crisis situation seclusion or restraint may be authorized and implemented for up to 2 hours by a staff member who has experience and training in the proper use of the procedure. The staff member must be physically present and evaluate, to the extent feasible, the child's physical and psychological condition. The staff member must consult with the QCCP as soon as possible to obtain verbal authorization to use the intervention. The QCCP must provide a written authorization/ order including any related documentation within 24 hours after implementation of the verbal authorization. The intervention may be used no longer than two (2) hours unless the QCCP is physically present to personally assess the child and write a new authorization/order to continue use of the intervention.

(iii) Authorizations/orders for seclusion or restraint are valid for no more than 8 hours. All written authorizations/ orders (including crisis situations) shall include a clinical assessment of the child, a description of precipitating events and alternative interventions attempted, and the criteria for the child's release.

(iv) Children must be released from seclusion or restraint when the criteria for release have been met or at the end of the time frame set out in the authorization/order, whichever occurs first. If additional time in seclusion or restraint appears to be needed, a QCCP must examine the child and write a new authorization/order. **Prescribed as Needed (PRN) orders are not to be used to authorize seclusion or restraint.**

(v) Restraint may be authorized when a child is transported from one location to another only because of threat of harm to self or others and only if there has been a documented dangerous incident within the past 14 days that clearly indicates restraint is necessary to prevent injury to the child or others.

2. **Release** - A child must be released from seclusion or restraint when the child is no longer a danger and in accordance with the release criteria outlined in the authorization/order. A child who falls asleep in

seclusion or restraint shall be released immediately. The person supervising the child must be aware of the steps necessary for the child to be released from restraint or to leave seclusion and the intervals when these steps should be attempted or repeated. If the child needs to remain in seclusion or restraint for a longer period than initially specified, a new authorization/order must be obtained. It must describe the basis for the belief that the child needs extended time in seclusion or restraint. The use of extended periods is to be reviewed at the child and family planning team meetings.

(g) **Documentation** - The use of seclusion or restraint must be documented in both the provider's and DHR's case records for the child. In addition, the provider's record for the child must maintain adequate documentation of a clinical assessment of the child including a description of precipitating events, any medical restrictions or prohibitions associated with the intervention, and alternative interventions attempted; the QCCP's written order identifying the intervention authorized, time frames for periodic observation, and criteria for termination, including the date, time, and duration the intervention was used, and presence or absence of contraindications; the periodic observation of the child's physical and psychological condition; the provision of meals, toilet opportunities, fluids on a regular basis, bathing and exercise, as needed; an assessment of the child's physical and emotional condition upon release; a medical evaluation of any injury suspected to be related to the use of seclusion or restraint; orders and related documentation issued during a crisis situation; evidence of timely reassessment of the intervention's use and its effects on the child; and evidence that decisions indicated by the reassessments and evaluations have been made.

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660-5-49-.05 Provider Responsibilities.

(1) **General Guidelines** - Child care institutions, group homes, shelters, other facilities, and licensed child placing agencies responsible for approving foster homes that serve children in the custody and/or planning responsibility of the Department are to develop written behavior management policy which includes procedures for emergencies and crisis situations. These facilities may adopt DHR policy or develop their own as long as it is consistent with Department policy and provides children the same

rights as children in DHR approved foster homes. Facilities which elect to develop their own behavior management policy must have the policy reviewed and approved by the State Department of Human Resources, Office of Agency Licensing. A provider's behavior management policy must be explained to all DHR-placed children and their parents so the family has a clear understanding of the policy. A copy of the facility's behavior management policy will be given to the parent(s) and/or legal custodian upon their request. These facilities may choose to apply Department policy to only those children placed by DHR. Providers who use isolation, seclusion, and/or restraint are to receive specialized or certified training in safely implementing these interventions as well as training in alternative, less restrictive interventions for managing behavior. Providers responsible for administering and monitoring medications must also receive training and instruction in the dispensing, storage, and disposal of medication, and how to administer medication and monitor the effects and potential side effects. Evidence of the proper storage, dispensing and disposal practices must be documented. Facilities shall also maintain documentation of all training received or provided. Training must meet generally accepted professional standards and be provided by a qualified source. In addition, facilities will survey their staff on an annual basis regarding training needs, and document in their resource or personnel files all plans or programs utilized to meet those needs. The Department will assist providers with locating training as needed.
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660-5-49-.06 DHR Responsibilities.

(1) **General Guidelines** - Plans designed to address behavioral needs must be systematic, based upon a careful assessment of the child's behavior, and utilize behavior management interventions which are in accordance with generally acceptable professional standards. Interventions will be based primarily on rewards, redirecting and re-education rather than punishment; consistently implemented in all areas of a child's life (e.g., school, church or leisure activities); implemented in a therapeutically appropriate manner according to the individual treatment plan developed by the provider; and timely evaluated for effectiveness. Children are to be referred to providers qualified and trained to authorize and implement behavior management interventions. **DHR staff shall be aware of a provider/facility's behavior management policy and may request a copy, when needed, to assure it is consistent with Departmental policy and provides children the same rights as children in DHR approved foster homes.** If the need for

intervention becomes apparent after placement, and the provider is not appropriately trained to authorize and implement the needed intervention, DHR shall assist the provider to secure the needed training.

(2) **Assessing Behavioral Needs** – DHR staff shall partner with the appropriate team members to explain and assist the age appropriate child and the child's family to understand the need for behavior management interventions. Assessments are to include information gathered from the social, medical, educational, psychological, and legal life domains (areas of family functioning) and will address child and family's strengths and needs; child's current and past behaviors; events, conditions or circumstances that trigger or affect the behavior; purpose the behavior serves and how it is displayed; frequency and duration of the behavior; previous interventions used to manage the behavior and their effectiveness; child's degree of readiness to learn self-control; and targeted areas for behavioral improvement and increased self-control. When a child's behavior indicates the need for medication, a medical assessment is required. The DHR worker is responsible for providing the physician with the child's history, information about the caregiver's capabilities and the changing needs of the child and family, and to assure the physician has explored alternative treatment interventions. (Refer to section on medication for more detailed information.)

(3) **Designing And Implementing The Behavior Management Plan** – Behavior management plans are to be individualized for each child, developed, and authorized in advance by the child and family planning team. The more restrictive interventions must also be authorized in advance unless there is a crisis situation. **The behavior management plan and any adjunct treatment plans must be documented in the ISP** and will include the child and family's strengths and needs as they relate to the desired behavioral outcomes; a clear description of the targeted behavior(s) to be managed (i.e. specific situation(s) where the behavior occurs, how it is displayed by the child, its frequency and duration); the desired outcomes for the targeted behaviors; the interventions to be used for teaching positive, alternative replacement behavior and how they will be implemented; the methods and frequency for evaluating the effectiveness of the interventions; and if applicable, the crisis plan outlining acceptable responses for managing dangerous behaviors. When case information reveals a child has a history of or the potential to display dangerous behavior, service provider and placement referrals are to be made to appropriately qualified and trained providers and placement resources. **The individualized service plan for these children must include a crisis plan outlining acceptable responses for managing the dangerous behavior.** Foster family home providers may use a behavior management intervention (e.g., prolonged grounding, exceeding defined time-out limits) which has not been previously authorized and documented in the individualized service plan when a crisis situation arises. The intervention will not be used any

longer than necessary to protect the child or others from harm or to help the child gain control. The foster parent must document use of the intervention and notify the DHR worker immediately (i.e., no more than one (1) working day later) of the crisis and subsequent use of the intervention. Residential providers may also use an intervention not previously authorized and documented in the individual service plan when a crisis arises. The residential provider must have a procedure in place which requires notification of a qualified child care professional (QCCP) who is available to assess the crisis and make decisions regarding the need for and use of the intervention. The same procedure used by foster family home providers regarding documentation, notification of the DHR worker, and review at the next ISP meeting is to be followed.

(4) **Assessing And Monitoring Behavior Management Interventions** - DHR shall work in partnership with providers as interventions are assessed for effectiveness in managing targeted behaviors. Assessment and monitoring shall occur according to the methods and frequency identified in the behavior management and individualized service plans. An intervention will be discontinued when it is no longer needed to manage a behavior or when the intervention is not effective and a more appropriate one has been identified.

(5) **Discharge Planning And Training For Managing Behaviors** – When changes in a child's placement or provider responsible for implementing behavior are going to occur, information must be supplied to the subsequent caregiver/provider and will include the child's behavior management plan including behavioral expectations and desired outcomes, prior interventions that have been both successful and unsuccessful, and current interventions used to manage the behavior(s). Training regarding behavior management intervention(s) used by the current caregiver/provider shall be provided to the parent(s), family member(s), or foster care provider to whom the child is expected to be discharged. Training on implementing the specific interventions shall be provided by a qualified source that has training and experience in the implementation of the behavior management interventions. The Department will assist the caregiver with locating any needed training.

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