Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE: FUNCTIONAL ASSESSMENT AND POSITIVE BEHAVIOR SUPPORT PLANNING FOR YOUTH RECEIVING OUT-OF-HOME SERVICES — POLICY 5.19

Authority:	42 C.F.R. Section 441.301(c)(4)	*Home and Community-Based Settings*
	Title 71A RCW	*Developmental Disabilities*
	Chapter 71A.26 RCW	*Client Rights*
	Chapter 388-826 WAC	*Out-of-Home Services*
	Chapter 388-845 WAC	*Home and Community-Based Services Waivers*
	Chapter 110-145 WAC	*Licensing Requirements for Group Care Facilities*
	Chapter 110-148 WAC	*Licensing Requirements for Child Foster Homes*

Reference:	DDA Policy 5.14	*Positive Behavior Support Principles*
	DDA Policy 5.16	*Psychotropic Medications*
	DDA Policy 5.20	*Restrictive Procedures and Physical Interventions with Children and Youth*
	DDA Policy 5.25	*Integrated Settings: Promoting Community Integration through Long-Term Services and Supports*
	DDA Policy 6.12	*Mandatory Reporting Requirements for Residential Services Providers*
	DDA Policy 12.01	*Incident Reporting*

BACKGROUND

All youth receiving residential habilitation from an Out-of-Home services provider through Home and Community-Based Services have access to physical and behavioral health entitlement benefits through Medicaid under Early and Periodic Screening, Diagnosis, and Treatment.

Residential habilitation is intended to help youth to acquire, retain, and improve upon self-help, socialization, and adaptive skills. This includes staff support to follow any medically necessary physical and behavioral health treatment plans from treating professionals.

The functional assessment and positive behavior support plan provided through residential habilitation are service planning tools intended to:

- Provide written instruction to staff on consistent behavior support interventions; and
- Complement and coordinate existing treatment plans.

Functional assessments and positive behavior support plans do not replace or substitute physical and behavioral health treatment plans.

PURPOSE

This policy establishes when a functional assessment (FA) and positive behavior support plan (PBSP) are required and establishes procedure, content, and timeline requirements for each. This policy also addresses restrictive procedures and physical interventions.

Refer to DDA Policy 5.20, *Restrictive Procedures and Physical Interventions with Children and Youth*, for information and requirements concerning the use of restrictive procedures and physical interventions.

SCOPE

This policy applies to DDA staff and the following Out-of-Home services providers:

1. A certified children's state-operated living alternative (SOLA).
2. A DDA-contracted provider licensed under Chapter 74.15 RCW as a:

    a. Child foster home;
    b. Staffed residential home; or
    c. Group care facility for medically fragile children.

DEFINITIONS

CRM means the Case Resource Manager or Social Service Specialist.

Youth means a DDA client age 20 or younger.

Consultant means the person who writes a client's FA and PBSP.

Data analysis means processing raw data into a graphic or table form.

Data collection is a systematic process of gathering information from a variety of sources on specific observable behaviors to inform decisions around a youth's treatment, learning, growth, and goal attainment.

Developmentally based approach means a structured intervention that focuses on each youth's individual differences and builds healthy foundations of emotional, social, and intellectual development by helping all providers, caregivers, and therapists to tailor the approach to the youth's unique developmental profile.

Emergency means an extreme hazard or an unanticipated, unpredicted action by a youth that presents an immediate risk to the health and safety to self, others, or property (e.g., when a youth is standing or sitting in the street or at immediate risk of danger from a fire).

Exclusionary time-out means the removal of a youth from a situation where positive reinforcement is available to an area where it is not, contingent on the occurrence of a specific behavior. This means a room used solely for the purpose of time out and where exiting the area is prevented. *This procedure is prohibited*.

Functional assessment or **Functional Behavior Assessment** (FA) means observing a youth, reviewing information about the youth, and collecting data about the youth to:

A. Determine relationships between antecedents and behaviors;
B. Identify reinforcing consequences; and
C. Form a hypothesis about why a behavior continues to be used.

Modification means changes that limit the choices of a client receiving residential services. Modifications must be documented in the client's person-centered service plan and other existing behavioral health plan or medical treatment plan.

Positive Behavior Support Principles as outlined in DDA Policy 5.14, *Positive Behavior Support Principles*, guides assessment, planning, and service provision.

Positive behavior support plan or PBSP means a plan designed to:

A. Strengthen or improve a youth's existing adaptive behaviors and skills;
B. Expand the youth's existing adaptive behaviors and skills to new tasks or settings;
C. Teach the youth new, adaptive behaviors and skills;
D. Provide supports to the youth;
E. Modify, reduce, and eliminate situations in the environment known to reinforce, setup, or cause target behaviors; and
F. Reduce or eliminate the use of target behaviors.

Provider means the Out-of-Home services provider who is state-operated or DDA-contracted and delivers the youth's residential habilitation.

Psychotropic medication means medication prescribed to treat a mental health condition, to improve functioning, to reduce target behaviors. Psychotropic medications include antipsychotics/neuroleptics, atypical antipsychotics, antidepressants, anticonvulsants, stimulants, sedatives/hypnotics, and anti-mania and anti-anxiety drugs. Anticonvulsants and other classes of drugs are included in this category when they are prescribed for behavioral purposes.

Restrictive procedure means a procedure that limits a youth's freedom of movement, restricts access to the youth's property, requires a youth to do something they do not want to do, or removes something the youth owns or has earned.

Target behavior means actions by the youth that constitute a threat to the youth's health and safety, the health and safety of others in the environment, a persistent pattern of behaviors that inhibit the youth's functioning in public places and integration with the community. These behaviors may have been present for long periods of time or have manifested as an acute onset and are identified by the provider that needs to be modified or replaced.

Teaching and training support means instruction to staff on how to set up a learning environment, introduce a skill or lesson, teach a skill or lesson, and document the results of a lesson.

POLICY

A. Positive behavior support principles must be emphasized in all DDA-funded services—for clients of all ages—with intellectual and developmental disabilities. This policy focuses on changing the physical and interpersonal environment of youth to increase their skill sets so the youth meet their needs without using a target behavior.

B. Along with positive behavior support principles, developmentally based approaches should be used to support the youth.

C. Non-restrictive teaching, training, and support methods must be used whenever possible. Procedures Section (I) of this policy contains a description of approved procedures and interventions that may be used and are not considered restrictive.

D. Positive Behavior Support

1. Positive behavior support principles help develop effective ways of meeting a youth's needs while reducing and preventing target behaviors.

2. Positive behavior supports must:

    a. Be implemented on an individual basis;

    b. Assist the youth to live in a safe, community-based setting with access to their community, activities, friends, and relatives; and

    c. Provide the youth assistance with and opportunities to:

        i. Make choices and exercise personal power as developmentally appropriate;

        ii. Choose daily activities, pursue personal goals, and access health care;

        iii. Form and maintain friendships and relationships; and

        iv. Participate in a broad range of activities in the home and in the community that the youth enjoys and that promote positive recognition by self and others.

3. Components of Positive Behavior Support

    a. Supportive Environments and Learning Opportunities

        i. A supportive environment helps a youth to meet their needs through positive expression, instead of utilizing target behaviors to get the environment to respond. In a supportive environment, supportive adults proactively plan to meet a youth's needs.

        ii. Many things contribute to a supportive environment, such as:

            A) Promoting warm and caring relationships between immediate and extended family members, school personnel, and paid support staff to the greatest extent possible;

            B) Increasing opportunities for the youth to make daily choices and decisions;

            C) Reducing factors that may make the youth feel threatened, anxious, afraid, angry, or devalued;

D) Arranging adaptations necessary for a youth to participate more fully in their immediate environment;

E) Providing consistent positive responses to the youth's appropriate behavior;

F) Providing a consistent, predictable environment;

G) Calmly interrupting and redirecting target behavior;

H) Assisting the child to understand why changing this behavior is important to the youth and useful for them, in a developmentally appropriate manner; and

I) Being a communication-rich environment, which could be spoken, visual, or sign language.

b. Skill Development and Status

i. Skill development and improvement help increase a youth's status and confidence. Skill acquisition is dependent on age, capabilities, interests, and personal motivation.

ii. Examples of skill development support may include supports in alignment with a behavioral health, speech hearing and language, physical therapy, or occupational therapy treatment plan:

A) Teaching the youth new skills to more effectively and appropriately satisfy wants and needs;

B) Improving the youth's functional communication skills;

C) Increasing the youth's participation in typical community activities;

D) Fostering skills and behaviors that promote mental and physical wellness;

E) Helping the youth find ways to make meaningful contributions to others; and

F) Encouraging the youth to take more responsibility as appropriate. This may mean experiencing negative (natural as well as logical) consequences for target behavior as well as positive consequences that help the youth learn socially appropriate behavior.

Note: Any such "negative" consequences must be in compliance with DDA Policy 5.20, *Restrictive Procedures and Physical Interventions with Children and Youth*.

c. Treatment of Physical and Behavioral Health

i. A youth with a developmental disability and a mental health condition or persistent behavior that negatively impacts their life or limits their ability to connect with others, should be referred to medical or behavioral health professionals to rule out physical and behavioral health conditions.

ii. Healthcare support must be offered to the youth to ensure prompt assessment, treatment, or rule out potential medical or behavioral concerns.

iii. If necessary, the CRM must request care coordination through the client's Managed Care Organization.

iv. Collaboration with healthcare providers should be incorporated into the development of the FA and PBSP.

v. Youth who are experiencing behavioral health conditions or symptoms should be evaluated by a mental health professional, preferably one with pediatric expertise in developmental disabilities.

vi. If the youth is prescribed psychotropic medication to address target behaviors, its use should be integrated into the larger plan to build a supportive environment for the youth.

E. FUNCTIONAL BEHAVIORAL ASSESSMENT

1. A functional behavioral assessment provides the basis for developing the youth's PBSP.

2. A functional behavioral assessment is an evaluation of:

   a. The overall quality of the youth's life;

   b. Factors or events that increase the likelihood of a target behavior occurring, including health factors that may contribute to target behaviors (e.g., urinary tract infections, constipation, gastroesophageal reflux disease (GERD), seizure disorders, headaches, possible medication side effects, and behavioral characteristics or traits associated with genetic syndromes);

   c. Factors or events that increase the likelihood of appropriate behavior;

   d. When and where target behaviors occur most frequently as well as conditions where the target behavior is least likely to occur;

   e. The presence of behavioral or neurological conditions that may contribute to target behaviors (e.g., anxiety, depression, confusion, attention problems, perception formation); and

   f. The function and purpose of a target behavior (what the youth obtains or avoids by engaging in the behavior).

3. The plan writer should make efforts to get input for the Functional Assessment and involvement in the proposed interventions from all relevant stakeholders including family, schools, mental health providers, and other community supports connected with the youth. This "wraparound" planning is the standard of care in serving youth with multiple systems involvement.

4. For guidelines on writing more effective FAs and PBSPs, refer to the Developer Manual.

F. POSITIVE BEHAVIOR SUPPORT PLANS (PBSP)

1. Family members should be included in designing strategies in the youth's PBSP. Better outcomes are achieved when families and professionals partner during the functional assessment and when families help identify strategies that will work for the youth.

2. When a PBSP is Required

For youth receiving residential habilitation, the provider must ensure the youth has a PBSP if any of the below are present:

a. The youth's person-centered service plan requires extensive supports to prevent:

i. Emotional outbursts;
ii. Suicide attempts;
iii. Sexual aggression;
iv. Self-injury;
v. Property destruction; or
vi. Assaults or injuries to others.

b. The child and family team determines that a modification to an integrated setting requirement is necessary.

Note: The PBSP must address the target behavior that limits full implementation of integrated settings.

c. The youth is taking psychotropic medications, including PRN medications to address target behaviors (for youth receiving DDA-funded services in a home or facility that is licensed, providers must adhere to Chapters 110-145 and 110-148 WAC in addition to this policy).

d. The use of certain restrictive procedures is planned or used. See DDA Policy 5.20, *Restrictive Procedures and Physical Interventions with Children and Youth.*

Note: The following are not considered restrictive procedures and do not require a PBSP unless there is a behavioral component:

i. Splints applied for purposes of physical therapy or other mechanical devices identified in written guidance from a treating professional that are used to maintain body posture (e.g., ankle-foot orthosis braces);

ii. Wheelchair safety (e.g., seatbelt);

iii. Protection from accidental injury (e.g., helmets for a youth with seizures or gait belts); or

iv. The use of car door locks for safety while in a moving vehicle.

e. The youth is transitioning from an Evaluation and Treatment Facility, a psychiatric hospitalization, or a residential treatment facility into Out-of-Home Services.

f. The youth has had three or more emergency room visits or hospital admissions in a six-month period due to mental health or behavioral needs.

g. The youth is at risk of losing their residential provider due to target behaviors.

h. The youth's provider plans to use door or window alarms to monitor a youth who presents a risk to themselves or others (e.g., lacks traffic skills, elopes, is physically or sexually assaultive).

i. The youth has a history of making threats or inflicting harm with items that need to be taken away or secured for safety due to being used as weapons (e.g., knives, matches, lighters).

j. It is necessary to remove the youth's property because it is being used to inflict injury on the youth, others, or cause property damage. This includes restricting access to the youth's personal belongings due to history of destructive behavior (e.g., storing clothing or art supplies outside a youth's room). The PBSP must include a timeline and directions for when the property will be returned to the youth.

Note: The use of restrictive procedures described in (i) and (j) above is allowed without a PBSP in an emergency situation to protect the health and safety of the youth or others. An incident report must be completed for each use. If the same procedure is used on an emergency basis more than three times in a six-month period, an FA must be conducted and a PBSP developed and implemented.

PROCEDURES

A. If a provider is considering using a restrictive procedure for protection, the provider must follow DDA Policy 5.20, *Restrictive Procedures and Physical Interventions with Children and Youth*.

B. If a provider uses a restrictive procedure or physical intervention during an emergency, the provider must complete an incident report according to DDA Policy 6.12, *Mandatory Reporting Requirements for Residential Service Providers*, and DDA Policy 12.01, *Incident Reporting*.

C. FA and PBSP Requirements

1. The written FA must include all of the following distinct sections in the assessment:

   a. A description of the youth's pertinent history;

   b. A detailed description of each target behavior;

   c. The data analysis and assessment used to conduct the functional assessment; and

   d. A summary statement describing the predictors and functions of each target behavior.

2. The written PBSP must include all of the following as distinct sections in the plan:

   a. A clear description of each target behavior;

   b. Prevention strategies;

   c. Teaching and training supports;

   d. Strategies for responding to target behaviors;

   e. Data collection plan and monitoring schedule to determine effectiveness of the PBSP; and

   f. A reduction or fade plan to eliminate the need for restrictive procedures as appropriate.

3. PBSPs require the following common elements:

   a. Recommendations for improving the general quality of a youth's life;

   b. Providing developmentally and therapeutically appropriate activities to complete the youth's day;

c. Strategies to avoid, minimize, or modify events that are likely to provoke the use of, or increase the rate of, each target behavior;

d. Methods to teach alternative replacement behaviors that will achieve the same function for the youth as the target behavior;

e. Methods to reduce the effectiveness of the target behavior in obtaining the desired outcomes;

f. Professional recommendations for supporting behavioral health and neurological conditions, as appropriate; and

g. Teaching, training, and support strategies appropriate to the youth's developmental level and readiness.

4. The author of a youth's PBSP must:

a. Be an employee of the provider or contracted with the provider as a:

i. Psychology associate if supporting a youth in a state-operated setting; or

ii. Consultant under WAC 110-145-1460 if supporting youth in a licensed setting.

b. Conduct a comprehensive review of the youth's other plans to identify interventions that can be adapted to be used in the PBSP. Examples of other plans include:

i. Applied Behavioral Analysis plan;
ii. Occupational Therapy plan;
iii. Speech-Language Pathology plan;
iv. Wraparound with Intensive Services plan;
v. A school-based Behavior Intervention Plan (BIP); and
vi. Medical or behavioral health evaluations or discharge summaries.

c. As appropriate, incorporate interventions and supports from the other plans that would enable direct care staff to effectively address target behaviors.

d. Send copies of the completed FA and PBSP to the youth's CRM.

e. Provide at least 30 minutes of training to direct care staff on new or updated PBSPs. Training should be sufficient to ensure staff use the plan and implement the plan as intended.

5. DDA psychologists, psychology associates, and other designated SOLA personnel must use the DDA FA and PBSP Template when authoring plans to be used in SOLA programs. FAs and PBSPs must contain all required sections of content and meet all policy requirements.

6. Contracted providers may use the DDA FA and PBSP Template. Alternatively, they may use their own format as long as the documents contain the required sections and content and otherwise meet all policy requirements.

D. FA and PBSP Timelines

1. For a new youth entering services who has been determined as requiring a PBSP, the provider:

a. Must initiate the functional assessment and PBSP before the youth enters service.

Note: Where possible and feasible, providers are encouraged to use transition funds for creating an FA and PBSP before the youth enters service. Upon request, the funds may be used for observation.

b. Must begin data collection no more than seven days after the youth enters service.

c. Must complete the FA no more than 45 calendar days after the youth enters service.

d. Must complete the PBSP and train staff to implement it no more than 60 calendar days after the youth enters service.

e. Provide at least 30 minutes of training to direct care staff on new or updated PBSPs. Training should be sufficient to ensure staff use the plan and implement the plan as intended.

2. If a provider identifies a new target behavior after a youth enters service, the provider must:

a. No more than seven days after the new target behavior is identified:

i. Provide direction to staff on how to keep the youth and others safe when the target behavior involves threats or acts of physical violence, property destruction, or self-harm; and

ii. Begin data collection and the FA development or revision process;

b. No more than 45 calendar days after identifying the new target behavior, update the new FA;

c. No more than 60 calendar days after identifying the new target behavior, train staff to implement the updated or completed PBSP; and

d. Inform the youth's treating professionals of the new behavior, if applicable.

3. If a physical restraint or restrictive procedure requiring a PBSP or an Exception to Policy is used on an emergency basis three times in six months, in addition to following DDA Policy 5.20, *Restrictive Procedures and Physical Interventions with Children and Youth*, the provider must:

a. No more than seven days after the third use of the emergency intervention:

i. Identify the new target behavior to be addressed;

ii. Provide direction to staff on how to keep the youth and others safe when the target behavior involves threats or acts of physical violence, property destruction, or self-harm; and

iii. Begin data collection and the FA development or revision process;

b. No more than 45 calendar days after identifying the new target behavior, update the new FA;

c. No more than 60 calendar days after identifying the new target behavior, train staff to implement the updated or completed PBSP; and

d. Inform the youth's treating professionals of the new behavior, if applicable.

4. The provider must submit written progress reports to the youth's CRM at least quarterly. Licensed residential providers must follow Chapters 110-145 and 110-148 WAC.

E. Plan Review and Revision

1. The provider must collect and analyze data to monitor the effectiveness of the plan as written and determine whether changes to the FA or PBSP are needed. The provider must review the plan and data collected at least every 30 days.

2. The provider must have a policy for monitoring data that addresses:

   a. Who will analyze the data;

   b. How often the data will be analyzed;

   c. How the data will be represented;

   d. When to elevate data analysis for a higher level of review within the provider's organization; and

   e. When to request assistance from DDA.

3. If the data indicate replacement behaviors are not increasing or target behaviors are not decreasing after a reasonable period, but no longer than six months, the provider must review and revise the FA and PBSP.

4. If the data indicate a target behavior is no longer occurring after three months, the FA and PBSP must be reviewed or revised.

5. Effective data collection:

   a. Tracks data for all target and replacement behaviors defined in the FA;

      Note: This does not require tracking of de-escalation techniques or the absence of the behavior.

   b. Measures the defined target and replacement behaviors;

   c. Collects data frequently enough to demonstrate trends;

d. Detects changes indicating the plan's effectiveness in decreasing target behaviors and increasing replacement behaviors; and

e. May include:

i. Record reviews;
ii. Interviews;
iii. Direct observation;
iv. Scatter plot forms;
v. Frequency counts;
vi. Interval data counts (whole, part, or partial interval); and
vii. Antecedent-Behavior-Consequence (A-B-C) data collection.

6. Effective data analysis processes raw data into:

a. Tables or charts to indicate:

i. Trends;
ii. Growth;
iii. Relative change; or
iv. Relative visual correlation of target and replacement behaviors.

b. Summary statistics estimate:

i. Baseline rates (frequency), length of time (duration), or intensities of behavior;

ii. How behavior fluctuates; or

iii. Project trends.

7. All PBSPs using restrictive procedures must collect data on the use of the restrictive procedure. The data collection system must be sufficient to document:

a. Setting conditions;
b. Triggering event;
c. Behavior indicating the need for protection;
d. Protective actions taken including the restrictive procedure; and
e. The youth's response prior to, during, and after the use of the restrictive procedure.

F. Annual Review of Functional Assessment and Positive Behavior Support Plan

Due to the multiple changes that occur as a child grows, the FA and PBSP must be reviewed and updated annually at minimum. The FA and PBSP must also be revised if a significant change occurs. Updates to the FA must include a description of the data and progress achieved since the previous FA and PBSP.

G. Review and Agreement of FAs and PBSPs

1. The client, if over 18, and the legal representative review the FA/PBSP. If there are questions or concerns, they can discuss with the provider and plan writer. Efforts should be made for consensus on the PBSP.

2. The following people must approve and sign the PBSP prior to distribution and implementation:

   a. Client if over 18;
   b. Parent or legal representative;
   c. Out-of-home services provider;
   d. Plan writer, if not a direct employee of the provider.

H. Distribution of FAs and PBSPs

1. Prior to implementation, the plan writer must send a copy of the PBSP to:

   a. The client (if over 18) and to the parent or legal guardian;
   b. The provider;
   c. The youth's CRM for review and inclusion in the youth's record.

2. The provider must make the PBSP available in electronic or hardcopy form in the youth's home for employees to access.

I. Teaching, Training, and Support Methods

The non-restrictive procedures and physical interventions listed below are commonly used teaching and training techniques. Using these procedures and interventions does not require a PBSP, although written plans and instructions may be helpful for direct support professionals.

1. <u>Examples of Non-Restrictive Procedures and Physical Interventions</u>

   a. Prompting (verbal and physical cues or gestures and physical assistance).

b. Simple correction (explaining or showing how to do something correctly, coaching or guiding the youth with or without physical assistance). Correction should always be demonstrated in a respectful manner.

c. Not attending to specific behaviors that are inappropriate (e.g., ignoring certain behaviors).

d. Offering or suggesting alternatives and discussing consequences of different behaviors.

e. Setting up incentive programs (e.g., chore chart) using tokens or points with special motivators (e.g., toys, activities, extra money, CDs, videos). These incentives must not be purchased with the youth's money.

f. Teaching and encouraging a youth to choose and purchase healthy, nutritional food.

g. Cancelling an activity because the youth is agitated at the time of the event. Providers must document all cancelled activities and the reason for the cancellation.

Note: If repeated cancellation of scheduled activities begins to limit the youth's access to their community, efforts should be made to develop a PBSP or modify the current plan to account for conditions leading up to the scheduled event cancellations.

h. Controlling access to prescription medications, over the counter medications, and hazardous chemicals that can be harmful (e.g., laxatives, cleaning products, insecticides). Licensed residential settings must adhere to Chapters 110-145 WAC in addition to this policy.

i. Physically blocking a youth for protection without holding them.

j. Requiring a youth to leave an area for protection without physical force. Also, when age appropriate, prompting a youth to take a break in order to allow the youth to calm down (e.g., stepping outside a restaurant with a youth when the behavior is escalating to allow time for them to calm down before returning to the table).

Note: This is not the same as a formal "time out room" or "exclusionary time out" (see Definitions section).

k. Use of medical code alert device for youth health and safety (e.g., food allergies, seizures, falls). Medical alert devices such as necklaces and bracelets may be worn on the youth.

l. Use of audio monitors for the youth's health and safety :

i. Audio monitors are permitted when medically necessary (e.g., for a youth who has frequent falls resulting in injury or uncontrolled seizures) under the following conditions:

A) Audio monitors must not be used for staff convenience or to invade a youth's privacy;

B) The youth must be aware of the monitor and the parent or legal guardian must give consent for its use. Such consent must be documented in the youth record; and

C) There is a written plan that includes the reason for use of the monitor and specific details as to when the monitor will be turned on and off. This plan must be documented in the youth record.

ii. Before the provider implements the plan above, the provider must send the CRM a copy of the written plan for inclusion in the youth's record.

iii. The CRM must notify the regional Field Services Administrator of the use of an audio monitor with the youth and document the notification in the youth record.

2. Use of Mechanical or Physical Restraints during Medical and Dental Treatment

The use of mechanical or physical restraints during medical and dental treatment is acceptable if under the direction of a physician or dentist consistent with standard medical and dental practices. Efforts should be made to familiarize the youth with the medical or dental procedure so that the least restrictive support is used.

3. No Contact and Protective Physical Intervention

The following protective interventions are not considered restrictive procedures and are permitted without a PBSP.

a. Avoiding: Eluding or escaping physical contact through the use of slides, stance, and arm or hand maneuvers without holding on to the youth's body.

b. Deflecting: Using physical contact such as step and guide maneuvers.

c. Blocking: Obstructing or hindering using physical contact.

d. Releasing: Escaping a physical hold. This may involve briefly holding on to the youth to release oneself or another person.

e. Physical escort that is not resisted by the youth: Briefly holding a youth, without unnecessary force, in order to calm the youth, or holding a youth's hand to safely escort them from one area to another.

f. Supporting ambulation: Physically holding a youth to steady or support the youth while walking to keep the youth from falling or slipping. This may involve the use of gait belts, specially designed belts, vests, or clothing under written guidance from the treating professional.

Note: The person doing the supporting follows the lead of the youth. The youth must be released when physical support is no longer needed to be safe.

EXCEPTION

Any exception to this policy must have the prior written approval of the Deputy Assistant Secretary or designee.

SUPERSESSION

DDA Policy 5.19, *Positive Behavior Support for Children and Youth*
Issued November 15, 2014

Approved: _____ Date: June 15, 2023
Deputy Assistant Secretary
Developmental Disabilities Administration