

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

FOSTER CARE BEHAVIOR MANGEMENT

ACKNOWLEDGEMENTS

Thanks to the writing committee for their hard work on the guidelines. The committee included Karen Brady, Peggy Brown, Susan Corwin, Jean Croisant, Sophia Kouidou-Giles, Janice Langbehn, Sharon Newcomer, Michael Nash, Wilma Pincham, Nancy Sutton, Michael Vander Meer, and Wendy Warman.

SUMMARY

In general, the guideline provides written expectations for foster parents on the use of strategies for the management of challenging child behaviors. The guideline was developed after a series of focus group meetings with providers and other stakeholders. We then brought together a writing committee. A number of changes have been made over the course of the review.

A summary of the major differences between current practice and the *Behavior Management Guide* follows:

- When the social worker and the foster parent agree the foster child presents challenging behaviors, the service plan should include a behavior management section.
- Restrictive strategies that would be permitted are a special timeout room, physical restraint, and mechanical restraint for safety purposes. Requirements are delineated for each.
- Each of the above three strategies require the following training:
 1. Training for working with challenging children (*current curriculum is Fosterparentscope*);
 2. General behavior management training (*minimum 8 hours*); and
 3. Specialized training in the specific technique to be used (*minimum 4 hours*).
- Documentation and notification of the social worker and licenser is required, if a foster parent uses a special timeout room, physical restraint, or mechanical restraints for safety reasons.

APPENDIX D
BEHAVIOR MANAGEMENT GUIDELINES
FOSTER CARE BEHAVIOR MANGEMENT

TABLE OF CONTENTS

	<i>Page</i>
I. FOUNDATION PRINCIPLES	1
II. GENERAL EXPECTATIONS FOR CARE PROVIDERS	2
➤ II. A. Positive Behavior Support	2
➤ II. B. Care Provider Team Membership	3
II. C. Care Provider Training Expectations	4
III. GENERAL EXPECTATIONS FOR SOCIAL WORKERS	4
➤ III. A. Social Worker Role in Placement	4
➤ III. B. Social Worker Role in Planning and Teaming	5
IV. BEHAVIOR MANAGEMENT STRATEGIES COVERED BY THIS GUIDELINE	6
IV. A. Situations Where Guideline Does Not Apply	6
IV. B. Interventions Which Are Prohibited	6
IV. C. Licensed Facility Reporting Requirements	7
V. LEAST RESTRICTIVE INTERVENTIONS	7
V. A. Selecting a Behavior Management Strategy	8
V. B. Giving Consequences as a Response to Inappropriate Behavior	9
VI. PERMITTED RESTRICTIVE STRATEGIES	10
VI. A. Restrictive Strategies Permitted in Foster Homes	10
VI. B. Training Required Before Using Restrictive Strategies	11
VII. PROCEDURES FOR USE OF RESTRICTIVE INTERVENTIONS	11
VII. A. Special Timeout Room	11
VII. B. Physical Restraint	12
VII. C. Emergency Use of Physical Restraint	13
VII. D. Use of Mechanical Restraints for Safety Reasons Related to Disability or Medical Condition	14

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

I. FOUNDATION PRINCIPLES

The Children's Administration (CA) expects each child in state care to reside in an environment in which the child is valued, respected and well cared for. CA is responsible to ensure that high quality care is provided to all children living in state-regulated homes or facilities. CA policy, rules and contracts define high standards for the care of children and licensed providers are encouraged to obtain on-going training to help them meet these standards for excellence.

Children in care with the CA Division of Children and Family Services (DCFS), like all children, should be guided and instructed so that they may grow to become adults who demonstrate self-control, compassion, respect for others and an ability to care for themselves. CA endorses national best practice standards which encourage adults working with children to set clear expectations and limits, develop regular routines, encourage cooperation and problem solving, and use a full range of positive interventions before using more intrusive interventions such as physical restraint or a de-escalation room. Interventions with children which are designed to modify their behavior should be respectful, related to the issue at hand, flexibly applied and designed to help the child master age and developmentally appropriate skills.

Out-of-home care providers must comply with discipline and restraint requirements contained in the Washington Administrative Code (WAC) minimum licensing requirements (MLR) for the category of license or certification held by the provider. WAC minimum licensing requirements are available from your licenser or from the CA Division of Licensed Resources (DLR). The minimum licensing requirements can also be found on the DSHS home page.

Agencies holding contracts for specialized services are expected to meet or exceed the care standards outlined in their contracts.

II. GENERAL EXPECTATIONS FOR CARE PROVIDERS

II. A. Positive Behavior Support

All out-of-home care providers licensed by the CA Division of Licensed Resources (DLR) must practice positive behavior support strategies for children in care. Positive behavior support is based on respect, dignity and offering choices (*as appropriate to the child's age and developmental level*). Positive behavior support helps children develop effective strategies for getting their needs met and helps reduce behavior problems. Components of positive behavior support include:

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

1. **Supportive environment:** A supportive environment ensures children get their needs met when they use socially acceptable behaviors. It reduces a child's need to use problem behaviors to obtain an adult response. Adults in a supportive environment:
 - a) Acknowledge the child's abilities and accomplishments;
 - b) Notice what the child does right and encourage more of that behavior;
 - c) Balance predictability and consistency with an ability to respond quickly to changes in the child's life and behavior; and
 - d) Recognize stressful circumstances (such as poor sleep, hunger, illness, parental visits, or court dates) and make reasonable adjustments in expectations for the child.

2. **Skill development:** Adults increase behavioral control skills in children by:
 - a) Explaining what is expected;
 - b) Redirecting ineffective behavior;
 - c) Offering choices;
 - d) Modeling how to negotiate and problem solve;
 - e) Supporting the child's efforts to effectively control her own behavior;
 - f) Being aware of and managing their own responses to challenging behaviors;
 - g) Providing a daily structure which supports the child's need for consistency;
 - h) Developing a list of response options and matching the intensity of the adult response to the seriousness of the child's behavior;
 - i) Giving consequences for unacceptable behavior;
 - j) Encouraging each child to be appropriately involved in school and community activities; and
 - k) Making sure each child has opportunities to form significant, positive friendships and family relationships.

3. **Health care:** Prompt assessment and treatment of any ongoing or suspected medical condition allows adults to better understand what behaviors can reasonably be expected of a child. Adults ensure appropriate health care by:
 - a) Acting on concerns they have about a child's health;
 - b) Obtaining a yearly well-child exam (*sometimes called a Healthy Kids exam or an EPSDT screen*) and dental exam;
 - c) Keeping all scheduled medical and therapeutic appointments;
 - d) Educating themselves about the nature of the child's illness or condition and its expected effects on the child's behavior;
 - e) Following the instructions of the doctor or pharmacist;
 - f) Educating themselves about prescribed medications and possible side effects; and
 - g) Sharing medical and prescription information with other caregivers, including respite providers.

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

II. B. Care Provider Team Membership

1. Out-of-home care providers, such as foster parents and staff of licensed group homes, are part of the professional team working to complete the permanency plan for the child and his or her family. (*Other team members will vary by child but should include the social worker, a parent and relatives when possible, school district personnel, therapist and other concerned adults.*) Care providers are expected to contribute to development of the child's permanent plan and to engage in activities that support achieving the permanent plan.
2. When foster parents identify emotional or behavioral issues that require further assessment or require specialized planning to manage, they are expected to inform the social worker. The foster parent is to be included in development of a service plan to meet the identified needs. Foster parents are expected to implement their portions of any specialized service plan.
3. Foster parents are encouraged to keep and share a record of the child's stay in their home or facility which includes:
 - a) Any medical reports received;
 - b) Significant developmental milestones;
 - c) Interests, skills and abilities of the child;
 - d) Behaviors of concern and management strategies;
 - e) Schools attended, report cards and grades;
 - f) Names of all medical providers and dates of visits;
 - g) Immunizations;
 - h) Friends, pets; and
 - i) Pictures of the child.

II. C. Care Provider Training Expectations

1. Children in the care of the state generally come from families where they have experienced abuse and/or neglect. They may demonstrate behaviors that reflect the abusive or neglectful treatment they have received. Foster parents are expected to obtain initial and on-going training to help them better understand the children in their care and to increase their ability to provide these children with a safe, stable and loving environment.
2. DLR offers training in every region designed to increase foster parent skills. Foster parents should take and complete training recommended or required by DLR.
3. Foster parents who wish to care for youth who receive exceptional cost payments (ECP), to support the child's needs, are required to complete specific training before

APPENDIX D BEHAVIOR MANAGEMENT GUIDELINES

they care for any child with an exceptional cost plan. More information is available from the child's social worker or regional foster parent trainer.

4. Respite providers must have the training needed to provide appropriate care for children under their supervision.

III. GENERAL EXPECTATIONS FOR SOCIAL WORKERS

The information in this section is adapted from the CA *Practices and Procedures Guide*, Chapter 4000 (Child Welfare Services), Section 4530 (Foster Care).

III. A. Social Worker Role in Placement

1. The social worker is responsible to ensure that when a child is placed in foster care the information needed to support that child is shared with the foster parent. In emergency placements of children not previously known to DCFS, the information may be scant. As more information is gathered, it must be shared with the care provider.
2. The social worker must provide the foster parent with as much relevant information as is known about the immediate condition of the child, the child's behaviors, school performance, health and medical condition, and those details of the permanency plan that will impact the child and the placement. Specific information to be provided includes:
 - a) Child's full name, birth date and legal status;
 - b) Last school of attendance and eligibility for special education and related services;
 - c) Medical history including any medical problems, name of doctor, type of medical coverage and provider;
 - d) Mental health history and any current mental health and behavioral issues;
 - e) Name and address of parent or guardian;
 - f) Reason for placement;
 - g) Who to contact in an emergency;
 - h) Special instructions including supervision requirements and suggestions for managing problem behavior;
 - i) Name and telephone number of the social worker and of the social worker's immediate supervisor; and
 - j) Visitation plan.
3. When possible, the social worker must arrange for and be involved in pre-placement visits and in the actual placement of the child in the foster home or residential setting.

APPENDIX D BEHAVIOR MANAGEMENT GUIDELINES

III. B. Social Worker Role in Planning and Teaming

1. As soon as possible after placement, the social worker makes a contact with the foster parent to see how the child is adjusting. The worker maintains, at a minimum, quarterly face-to-face contact with the child in the foster home.
2. The social worker uses a team approach in planning for each child. The social worker contacts the care provider and other concerned adults and considers their input before developing plans for a child.
3. When the social worker and the foster parent agree upon the child's challenging behaviors, the service plan which is developed must include a behavior management section which is individualized for the child and which addresses:
 - a) Things known to contribute to problem behaviors for the child;
 - b) Supervision needs;
 - c) Strategies for early intervention and de-escalation;
 - d) A list of ways to respond if de-escalation is not working; and
 - e) A plan for obtaining crisis consultation and support 24 hours a day.
4. The social worker documents the service plan including behavior management section in the child's Passport and/or in CAMIS as described elsewhere in agency policy.

IV. BEHAVIOR MANAGEMENT STRATEGIES COVERED BY THIS GUIDELINE

Certain children will require behavioral interventions beyond those generally appropriate for the child's age and developmental level. These children are behaviorally reactive in ways that may pose a continuing serious threat to themselves, to others or to property. This guide provides information that will help with managing these behaviors with the goal of assisting the child to gain control of his or her own behavior.

IV. A. Situations Where This Guideline Does Not Apply

This guideline does not apply to age related, developmentally normal behaviors demonstrated by very young children that may require physical intervention. Some examples of appropriate adult interventions are listed below:

1. Intervening physically to ensure safety when a child demonstrates dangerous, impulsive behavior. An example of this is physically holding a three-year-old child who has suddenly tried to dart into the street.

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

2. Intervening physically to remove a child from a situation that is so stimulating the child is overwhelmed. An example of this is physically removing a tantruming two-year-old from a supermarket floor to the quiet of the car.
3. Appropriately using standard, industry approved infant and child safety restraints. Some examples include car seats, high chairs with safety belts, toddler harnesses and toddler safety gates.
4. Following steps outlined in an alternative behavior management plan for developmentally disabled children when a separate plan has been developed.

IV. B. Interventions Which Are Prohibited

The following interventions are prohibited in all licensed homes and facilities:

1. ***Corporal punishment of any kind.*** Examples of corporal punishment include but are not limited to: spanking with a hand or object, biting, jerking, kicking, shaking, pulling hair, or throwing the child;
2. ***Behavioral control methods that interfere with the child's right to humane care.*** Examples of methods which interfere with humane care include but are not limited to: deprivation of sleep, providing inadequate food, purposely inflicting pain as a punishment, name-calling or using derogatory comments, verbal abuse, or actions intended to humiliate;
3. ***Depriving a child of the components of humane care.*** Examples of the components of humane care include but are not limited to: necessary clothing, personal hygiene, adequate shelter, adequate food, and necessary medical or dental care;
4. ***Depriving the child of necessary services.*** Examples of necessary services include but are not limited to: contact with the assigned social worker, contact with the assigned legal representative, family contacts and/or therapeutic activities which are part of the child's DCFS Individual Service and Safety Plan (ISSP);
5. ***Use of medication in an amount or frequency other than that which has been prescribed by a physician or psychiatrist;***
6. ***Giving medications that have been prescribed for another person;***
7. ***Physically locking doors or windows in a way that would prohibit a child from exiting except as described in section VII. E (De-escalation Room with Spring Lock on Door) and section VIII. (Secure Crisis Residential Centers).***

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

8. *Physical restraint techniques which restrict breathing;*
9. *Physical restraint techniques that inflict pain as a strategy for behavior control;*
10. *Mechanical restraints used as a punishment.* See section VII. F (*Use of Mechanical Restraints for Safety Reasons Related to Disability or Medical Condition*) for description of allowed use of mechanical restraints; and
11. *Any activity that interferes with the child's basic right to humane care, protection, safety and security.*

IV. C. Licensed Facility Reporting Requirements

Any incident that meets the reporting requirements established by DLR for licensed facilities (*foster homes, group homes or other residential facility*) must be reported to CA Intake. The reporting requirements are published in the CA *Practices and Procedures Guide* and are available from your licenser.

V. LEAST RESTRICTIVE INTERVENTIONS

Foster parents must use the least restrictive procedure that adequately protects the child, other persons, or property. Potentially dangerous situations may often be defused if the care provider is alert, intervenes early to change the environment if appropriate, and uses active listening and de-escalation techniques.

Less restrictive interventions must be tried before more restrictive interventions are used unless there is serious threat of injury to the child or others or of serious property damage. Less restrictive interventions may be repeated many times to allow opportunities for learning to occur and the behavior to change.

V. A. Selecting A Behavior Management Strategy

Foster parents must be able to select a behavior management strategy or approach that is appropriate for the child, the behavior and the setting. In order to select an effective response that is appropriate to the level of risk posed by the behavior, foster parents must understand the following behavior management concepts:

1. Challenging behavior may be an indication of the child's need for greater positive adult support and attention.
2. A child may break rules in a premature effort to assume responsibility rather than in defiance of adult authority.

APPENDIX D BEHAVIOR MANAGEMENT GUIDELINES

3. Adults may still provide effective guidance when they:
 - a) Allow the child to make mistakes as part of the learning process;
 - b) Occasionally ignore behavior; and
 - c) Allow the child to learn by experiencing the natural consequences of the behavior. Allowing natural consequences to occur is not an appropriate strategy if the consequence poses additional risk to the child. For example, it would not be appropriate to let a youth walk home at 10:00 PM because he spent his bus money.
4. Positive activities such as shooting hoops or journal writing can help children redirect excess energy or anger.
5. Challenging behaviors can often be redirected through the use of active listening and verbal de-escalation techniques.
6. Early intervention with risky behaviors may be necessary to prevent further acting out and reduce risk of harm to the child or others.
7. All behavior change strategies selected must be appropriate to the child's ability to understand; and
8. Greater objectivity and effectiveness may be gained by consulting with other team members in selecting a strategy.

V. B. Giving Consequences as a Response to Inappropriate Behavior

This section applies to all licensed out-of-home care providers. Giving a child a consequence for inappropriate behavior is considered a "less restrictive" intervention. The types of consequences used should be discussed with the child during a calm time whenever possible. All care providers are encouraged to obtain training in general behavior management strategies. Developmentally disabled clients may require a different approach or strategy than those described below. Consult with the DDD caseworker as appropriate.

1. Foster parents may assign consequences for inappropriate behavior.
 - a) When consequences are used, they must be discussed with the child in such a way that they help the child gain self-control skills and encourage the child to make positive behavior choices.
 - b) The assigned consequence must not pose additional risk to the child. For example, a foster parent may not make a child spend the night outside because she came home after curfew.

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

- c) Foster parents assigning a consequence must keep in mind the child's unique circumstances, history, age, developmental level, mental health issues, and cognitive abilities.
 - d) If the chosen consequence isn't working, adjust it quickly. Do not give up on the behavior plan. Find consequences that are effective.
2. Examples of consequences that are permitted include:
- a) Allowing events to occur which are a natural or logical outcome of the behavior;
 - b) Giving a timeout (*briefly sending the child to a common area such as a bedroom or a special chair in the living room. Generally, one minute per year of age*);
 - c) Meetings to discuss the behavior and strategies for change;
 - d) Extra chores appropriate for the child's age and abilities;
 - e) Loss of privileges such as television or telephone;
 - f) Early bed time/early curfew;
 - g) Time limited restriction from planned recreational activities;
 - h) Restricted access to areas generally available to the children in care;
 - i) Increased adult supervision;
 - j) Temporary removal of personal property used (*or threatened to be used*) by the child to inflict injury on self or others;
 - k) Restricting the child from possessing certain items; and
 - l) Searches of personal property for restricted items.

VI. PERMITTED RESTRICTIVE STRATEGIES

CA expects that foster parents will work cooperatively, as part of a team, with social workers and other concerned adults to develop appropriate plans for management of a child's behaviors. More information on this expectation is contained in Section II. General Expectations for Care Providers, and Section III. General Expectations for Social Workers.

VI. A. Restrictive Strategies Permitted in Foster Homes

1. Specialized training is **required** before a restrictive strategy may be used in a foster home setting. Each foster parent using a restrictive strategy must have completed DLR required training for working with challenging children (*current curriculum is FosterparentScope*) and a general behavior management training that addresses the theories and concepts outlined in section V. Least Restrictive Interventions. In addition, the foster care provider must have received specialized training in the technique being used (physical restraint, use of a mechanical restraint).
2. Restrictive behavior management strategies permitted in foster home settings after appropriate training has been completed include:

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

- a) Use of a special unlocked timeout room in certain settings as described in section VII. A. Timeout Room;
- b) Physical restraint as described in Section VII. B. Physical Restraint; and
- c) Mechanical restraint only for safety purposes as described in Section VII. F. Use of Mechanical Restraints for Safety Reasons.

VI. B. Training Required Before Using Restrictive Strategies

Before foster parents may use a restrictive behavior management strategy, the foster parent must have received DLR required training for working with challenging children (*current curriculum is Fosterparentscope*), general training in behavior management, and specific training in how to use the strategy being applied. Behavior management training must be documented and available for review and comment by DSHS staff.

1. **General behavior management training** must address the following topics at a minimum:
 - a) Recognizing events that could contribute to a crisis;
 - b) Assessing the physical environment;
 - c) Assessing personal response to challenging behaviors;
 - d) Verbal and non-verbal de-escalation strategies;
 - e) Selecting an intervention strategy that is appropriate to the situation;
 - f) Assessing when to end the use of the restrictive technique;
 - g) Debriefing the incident with the child and other adults; and
 - h) Incorporating knowledge gained into the service plan or treatment plan.
2. In order to adequately cover the topics listed above, general behavior management training should be no less than eight hours.
3. **Specialized training** must contain discussion of issues and instruction on procedures that are associated with the specific restrictive technique. For each restrictive technique, it is appropriate to receive a minimum of four to eight hours of specialized instruction.
4. Specialized instruction on a restrictive technique must address the following at a minimum:
 - a) Balancing child safety with temporary loss of freedom due to use of the restrictive technique;
 - b) How to appropriately apply the restrictive technique;
 - c) How to monitor and document use of the restrictive technique;
 - d) Assessing when to end use of the restrictive procedure;

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

- e) Training and instruction strategies for the child which may reduce the need to use the restrictive technique; and
- f) Incorporating information gained into the child's service plan or treatment plan.

VII. PROCEDURES FOR USE OF RESTRICTIVE INTERVENTIONS

VII.A. Special Timeout Room

A *special* timeout room which is located away from the activities of daily life may be used either as a consequence for poor behavior or to help a child gain behavioral control. *This is a room separate from the child's bedroom or other living spaces.*

1. The purpose of timeout is to provide the child with some time to think and some distance from a difficult situation. Adults must explain to the child why a timeout was given and must help the child consider more appropriate ways to manage similar situations.
2. Generally, when a young child is given a timeout, it is appropriate for the child to spend one minute in timeout per each year in age. This expectation should be individually adjusted as needed to match the developmental age of the child.
3. A *special* timeout room:
 - a) May not have a locking device of any type on the door;
 - b) Must meet the WAC requirement for a single bedroom including lighting, heating and adequate size;
 - c) Must be designed so that the child is visible while in the room;
 - d) Must have a comfortable atmosphere;
 - e) May be used only for brief amounts of time. Any period of time longer than 30 minutes requires written approval by the social worker for the child;
 - f) Must not allow any child to remain in isolation for more than four hours in a 24-hour period;
 - g) Requires a staff person to visually observe the child at least once in each 15-minute period;
 - h) Requires the child to be protected from any means of self-harm;
 - i) Requires documentation of the length of time and reason the child was placed in the timeout room; and
 - j) May be used for only one child at a time.
4. A *special* timeout room in a foster setting would be appropriate when children share a bedroom or the bedroom is not available as a timeout setting.

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

5. DLR must be notified that a *special* timeout room is planned, and DLR must have the opportunity to physically inspect the space for appropriateness.

VII.B. Physical Restraint

If physical restraint is necessary, it should be used primarily as part of a treatment and intervention plan for a child with identified behavior management difficulties. General behavior management training and specialized instruction on the use of physical restraint is required before use.

1. Physical restraint may be used only to prevent a child from:
 - a) Seriously injuring self or others;
 - b) Carrying out a believable threat to seriously injure self or others;
 - c) Seriously damaging property; or
 - d) Harm when needing to safely move a child to a less risky location.
2. Efforts to redirect or de-escalate the situation must be attempted before using a physical restraint unless the child's behavior poses an immediate risk to physical safety.
3. Physical restraint may not be used as a form of punishment.
4. Physical restraint techniques which restrict breathing or which inflict pain as a strategy for behavior control are prohibited.
5. Physical restraint may be used only:
 - a) For a short time to provide the physical control that the child is unwilling or unable to provide for himself; and
 - b) For the purpose of promoting safety.
6. When the child verbally or non-verbally demonstrates an ability to control his behavior, the restraint is to be ended.
7. If escalated behavior persists, other options such as use of a special timeout room or de-escalation room should be considered, if available. Psychiatric hospitalization or police involvement should be considered if the child's presentation and behavior appear to meet the criteria for involvement by those resources.
8. Children being restrained must be continually monitored, ideally by someone not involved in the restraint, to ensure the child's health and safety.

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

9. Each use of physical restraint must be documented in writing. At a minimum, the documentation must record:
 - a) The child's name and age;
 - b) The date of the restraint;
 - c) The time in and time out of the restraint;
 - d) The events preceding the behavior which lead to use of the restraint;
 - e) The de-escalation strategies that were used;
 - f) Names of those involved in the restraint and any observers;
 - g) A description of the restraint;
 - h) A description of any injuries to the child, other children or caregivers;
 - i) An analysis of how the restraint might have been avoided; and
 - j) Signature of report author.

10. Foster parents must send documentation of the physical restraint to the child's social worker, licenser and keep a copy in their records.

VII.C. Emergency Use of Physical Restraint

Some children placed in foster care by CA will demonstrate unexpected behaviors that the provider is not specifically trained to manage.

1. If a child's behavior presents an immediate risk of serious harm to the child or others, or a serious threat to property, a physical restraint may be used *in this emergency situation* to ensure safety even if the foster parent has not received specialized training in this procedure.
2. The least restrictive procedure that will provide adequate protection must be used and it must be ended as soon as the need for protection is over.
3. Physical restraint techniques which inhibit breathing or which inflict pain for behavior control purposes are prohibited.
4. A report describing the restraint must be written by the foster parent and mailed or delivered to the social worker and licenser within 48 hours of each use of an emergency physical restraint. The report must identify the child and the foster parent, describe the events leading to use of the emergency restraint, the persons involved, the type of restraint used, whether there were any injuries, and how the incident was resolved.
5. When an emergency physical restraint has been used on a child, the foster parent and social worker must consult about
 - a) Immediate strategies for behavior management;

APPENDIX D BEHAVIOR MANAGEMENT GUIDELINES

- b) Whether the service plan adequately identifies and meets the needs of the child;
and
 - c) Whether the child will remain in the current placement.
6. If the child remains in the current placement, the foster parent must obtain general and specialized behavior management training within three months. This training would include the appropriate use of restraints.

VII.D. Use of Mechanical Restraints for Safety Reasons Related To Disability or Medical Condition

A mechanical restraint is any object or device that is applied to the child to limit movement. Some developmentally disabled or medically fragile children may require mechanical devices to assist them with body positioning or to reduce opportunities for self-injury or wandering.

1. The following assistance devices are excluded:
 - a) Age appropriate, infant and toddler safety devices;
 - b) Orthopedic braces;
 - c) Automobile and wheelchair safety belts.
2. Mechanical restraint for punishment purposes is prohibited in all licensed out-of-home care settings.
3. Mechanical restraint for safety purposes is permitted only when DLR has given the care provider a written waiver to the license that authorizes the provider to use a specific mechanical restraint for a specific child. These waivers are time limited and must be renewed.
4. Before using a mechanical restraint, the foster parent, social worker, and health care provider must weigh the child's right to freedom of movement against the potential for injury to the child, if the restraint is not used.
5. When a mechanical restraint is being used with a child, the foster parent, social worker, physician (or designee), and other adults responsible for the child must regularly engage in discussions about whether the restraint is still needed and whether there are other less restrictive methods that could benefit the child. This consideration of other options must be documented by the social worker as part of the quarterly health and safety contact.
6. Before any mechanical restraint can be used, there must be a medical order signed by the child's physician, for this intervention. The medical order must:

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

- a) Describe the specific restraint to be used and the circumstances in which it is to be used;
 - b) Identify the caregiver skills and knowledge needed to apply the restraint correctly; and
 - c) Suggest strategies for intervention that might reduce future need for use of the mechanical restraint.
7. An out-of-home care provider who has received a waiver to utilize a mechanical restraint must obtain training in the safe and appropriate use of the restraint in their setting. Any substitute or respite care providers must also be trained in safe and appropriate use of the restraint device.
8. A building evacuation plan must be written which clearly states who will be responsible for evacuating each restrained child in an emergency. When substitute care providers are on duty they must be informed of the building evacuation plan and which children they will be responsible for in the event of an emergency.

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

GROUP CARE BEHAVIOR MANGEMENT

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SUMMARY

In general, the guideline provides written expectations for care providers on the use of strategies for the management of challenging child behaviors. The guideline was developed after a series of focus group meetings with providers and other stakeholders. We then brought together a writing committee. A number of changes have been made over the course of the review.

A summary of the major differences between current practice and the Behavior Management Guide for residential care settings follows:

- Restrictive strategies that would be permitted are a special time-out room, physical restraint, mechanical restraint for safety reasons related to disability or medical condition, de-escalation room, and de-escalation room with a spring or gravity lock. Requirements are delineated for each strategy in the guideline. There are specific requirements in regard to training, documentation and notification.
- De-escalation room with a spring or gravity lock door. This behavior management technique may only be used to assist in the control of youth that are large enough or aggressive enough that injury to the youth or staff is likely without its use.
 - This is a very restrictive strategy that requires a determination of “need” for such an option (*decision made jointly by the Division of Children and Family Services (DCFS) Regional Administrator, the Division of Licensed Resources (DLR) Regional Manager, and the Children’s Administration (CA) Directors of Licensed Resources and Program and Policy Development*);
 - There is a separate application to DLR for the use of this strategy;
 - Current certification of accreditation by COA or JCAHO or equivalent is required; and
 - A waiver granted by DLR with an appropriate plan for use of the locked room.

APPENDIX D
BEHAVIOR MANAGEMENT GUIDELINES
GROUP CARE BEHAVIOR MANGEMENT

TABLE OF CONTENTS

	<i>Page</i>
I. FOUNDATION PRINCIPLES	1
II. GENERAL EXPECTATIONS FOR CARE PROVIDERS	1
II. A. Positive Behavior Support.....	1
II. B. Care Provider Team Membership.....	3
II. C. Care Provider Training Expectations.....	3
III. GENERAL EXPECTATIONS FOR SOCIAL WORKERS	4
III. A. Social Worker Role in Placement.....	4
III. B. Social Worker Role in Planning and Teaming.....	5
IV. BEHAVIOR MANAGEMENT STRATEGIES COVERED BY THIS GUIDELINE	5
IV. A. Situations Where This Guideline Does Not Apply.....	5
IV. B. Interventions Which Are Prohibited.....	6
IV. C. Licensed Facility Reporting Requirements.....	7
V. LEAST RESTRICTIVE INTERVENTIONS	7
V. A. Selecting A Behavior Management Strategy.....	7
V. B. Giving consequences as a Response to Inappropriate Behavior.....	8
VI. PERMITTED RESTRICTIVE STRATEGIES	9
VI.A. Restrictive Strategies Permitted in Residential Facilities.....	9
VI.B. Training Required Before Using Restrictive Strategies.....	10
VII. PROCEDURES FOR USE OF RESTRICTIVE INTERVENTIONS	11
VII.A. Special Timeout Room.....	11
VII.B. Physical Restraints.....	12
VII.C. Emergency Use of Physical Restraint.....	13
VII.D. De-escalation Room in Residential Treatment Facilities.....	14
VII.E. De-escalation Room with Spring or Gravity Locks.....	16
VII.F. Use of Mechanical Restraints for Safety Reasons Related to Disability or Medical Condition.....	17
VIII. SECURE CRISIS RESIDENTIAL CENTERS	18

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

I. FOUNDATION PRINCIPLES

The Children's Administration (CA) expects each child in state care to reside in an environment in which the child is valued, respected and well cared for. CA is responsible to ensure that high quality care is provided to all children living in state-regulated homes or facilities. CA policy, rules, and contracts define high standards for the care of children, and CA encourages licensed providers to obtain on-going training to help them meet these standards for excellence.

Children in care with the CA Division of Children and Family Services (DCFS), like all children, should be guided and instructed so that they may grow to become adults who demonstrate self-control, compassion, respect for others, and an ability to care for themselves. CA endorses national best practice standards which encourage adults working with children to set clear expectations and limits, develop regular routines, encourage cooperation and problem solving, and use a full range of positive interventions before using more intrusive interventions such as physical restraint or a de-escalation room. Interventions with children which are designed to modify the children's behavior should be respectful, related to the issue at hand, flexibly applied, and designed to help the children master age and developmentally appropriate skills.

Out-of-home care providers must comply with discipline and restraint requirements contained in the Washington Administrative Code (WAC) minimum licensing requirements (MLR) for the category of license or certification held by the provider. WAC minimum licensing requirements are available from your licenser or from the CA Division of Licensed Resources (DLR). The minimum licensing requirements may also be found on the DSHS home page.

Agencies holding contracts for specialized services are expected to meet or exceed the care standards outlined in their contracts with the department.

II. GENERAL EXPECTATIONS FOR CARE PROVIDERS

II. A. Positive Behavior Support

All out-of-home care providers licensed by Division of Licensed Resources (DLR) must practice positive behavior support strategies for children in care. Positive behavior support is based on respect, dignity and offering choices (*as appropriate to the child's age and developmental level*). Positive behavior support helps children develop effective strategies for getting their needs met and helps reduce behavior problems. Components of positive behavior support include:

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

1. **Supportive Environment:** A supportive environment ensures children get their needs met when they use socially acceptable behaviors. It reduces a child's need to use problem behaviors to obtain an adult response. Adults in a supportive environment:
 - a) Acknowledge the child's abilities and accomplishments;
 - b) Notice what the child does right and encourage more of that behavior;
 - c) Balance predictability and consistency with an ability to respond quickly to changes in the child's life and behavior; and
 - d) Recognize stressful circumstances (*such as poor sleep, hunger, illness, parental visits, or court dates*) and make reasonable adjustments in expectations for the child.

2. **Skill Development:** Adults increase behavioral control skills in children by:
 - a) Explaining what is expected;
 - b) Redirecting ineffective behavior;
 - c) Offering choices;
 - d) Modeling how to negotiate and problem solve;
 - e) Supporting the child's efforts to effectively control her own behavior;
 - f) Being aware of and managing their own responses to challenging behaviors;
 - g) Providing a daily structure which supports the child's need for consistency;
 - h) Developing a list of response options and matching the intensity of the adult response to the seriousness of the child's behavior;
 - i) Giving consequences for unacceptable behavior;
 - j) Encouraging each child to be appropriately involved in school and community activities; and
 - k) Making sure each child has opportunities to form significant, positive friendships and family relationships.

3. **Health Care:** Prompt assessment and treatment of any ongoing or suspected medical condition allows adults to better understand what behaviors can reasonably be expected of a child. Adults ensure appropriate health care by:
 - a) Acting on concerns they have about a child's health;
 - b) Obtaining a yearly well-child exam (*sometimes called a Healthy Kids exam or an EPSDT screen*) and dental exam;
 - c) Keeping all scheduled medical and therapeutic appointments;
 - d) Educating themselves about the nature of the child's illness or condition and its expected effects on the child's behavior;
 - e) Following the instructions of the doctor or pharmacist;
 - f) Educating themselves about prescribed medications and possible side effects; and

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

- g) Sharing medical and prescription information with other caregivers, including respite providers.

II. B. Care Provider Team Membership

1. Out-of-home care providers such as foster parents and staff of licensed group homes/residential facilities are part of the professional team working to complete the permanency plan for the child and his or her family. Other team members will vary by child but should include the social worker, a parent and relatives when possible, school district personnel, therapist and other concerned adults. Care providers are expected to contribute to development of the child's permanent plan and to engage in activities that support achieving the permanent plan.
2. When out-of-home care providers identify emotional or behavioral issues that require further assessment or require specialized planning to manage, they are expected to inform the social worker. The care provider is to be included in development of a service plan to meet the identified needs. The care providers are expected to implement their portions of any specialized service plan.
3. Out-of-home care providers are encouraged to keep and share a record of the child's stay in their home or facility which includes:
 - a) Any medical reports received;
 - b) Significant developmental milestones;
 - c) Interests, skills and abilities of the child;
 - d) Behaviors of concern and management strategies;
 - e) Schools attended, report cards and grades;
 - g) Names of all medical providers and dates of visits;
 - h) Immunizations;
 - i) Friends, pets; and
 - j) Pictures of the child.

II. C. Care Provider Training Expectations

1. Children in the care of the state generally come from families where they have experienced abuse and/or neglect. They may demonstrate behaviors that reflect the abusive or neglectful treatment they have received. Out-of home care providers are expected to obtain initial and on-going training to help them better understand the children in their care and to increase their ability to provide these children with a safe, stable and loving environment.

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

2. All child care staff, in residential settings, are expected to participate in the training opportunities available through their agencies that are designed to increase their skills in the care of challenging behaviors of the children cared for.
3. Respite providers must have the training needed to provide appropriate care for children under their supervision.

III. GENERAL EXPECTATIONS FOR SOCIAL WORKERS

The information in this section is adapted from the Children's Administration Practices and Procedures Guide, Chapter 4000, Child Welfare Services, Section 4530, Foster Care.

III.A. Social Worker Role in Placement

1. The social worker is responsible to ensure that when a child is placed in foster care or residential care the information needed to support that child is shared with the care provider. In emergency placements of children not previously known to DCFS, the information may be scant. As more information is gathered, it must be shared with the care provider.
2. The social worker must provide the out-of-home care provider with as much relevant information as is known about the immediate condition of the child, the child's behaviors, school performance, health and medical condition, and those details of the permanency plan that will impact the child and the placement. Specific information to be provided includes:
 - a) Child's full name, birth date and legal status;
 - b) Last school of attendance and eligibility for special education and related services;
 - c) Medical history including any medical problems, name of doctor, type of medical coverage and provider;
 - d) Mental health history and any current mental health or behavioral issues;
 - e) Name and address of parent or guardian;
 - f) Reason for placement;
 - g) Who to contact in an emergency;
 - h) Special instructions including supervision requirements and suggestions for managing problem behavior;
 - i) Name and telephone number of the social worker and of the social worker's supervisor; and
 - j) The visitation plan.

APPENDIX D BEHAVIOR MANAGEMENT GUIDELINES

3. When possible, the social worker must arrange for and be involved in pre-placement visits and in the actual placement of the child in the foster home or residential setting.

III.B. Social Worker Role in Planning and Teaming

1. As soon as possible after placement, the social worker makes a contact with the care provider to see how the child is adjusting. The worker maintains, at a minimum, quarterly face-to-face contact with the child in the out-of-home care setting.
2. The social worker uses a team approach in planning for each child. The social worker contacts the care provider and other concerned adults and considers their input before developing plans for a child.
3. When the social worker and the care provider agree upon the child's challenging behaviors, the service plan which is developed must include a behavior management section which is individualized for the child and which addresses:
 - a) Things known to contribute to problem behaviors for the child;
 - b) Supervision needs;
 - c) Strategies for early intervention and de-escalation;
 - d) A list of ways to respond if de-escalation is not working; and
 - e) A plan for obtaining crisis consultation and support 24 hours a day.
4. The social worker documents the service plan including behavior management section in the child's Passport and/or in CAMIS as described elsewhere in agency policy.

IV. BEHAVIOR MANAGEMENT STRATEGIES COVERED BY THIS GUIDELINE

Certain children will require behavioral interventions beyond those generally appropriate for the child's age and developmental level. These children are behaviorally reactive in ways that may pose a continuing serious threat to themselves, to others or to property. This guideline provides information that will help with managing these behaviors with the goal of assisting the child to gain control of his or her own behavior.

APPENDIX D BEHAVIOR MANAGEMENT GUIDELINES

IV.A. Situations Where This Guideline Does Not Apply

This guideline does not apply to age related, developmentally normal behaviors demonstrated by very young children that may require physical intervention. Some examples of appropriate adult interventions are listed below:

1. Intervening physically to ensure safety when a child demonstrates dangerous, impulsive behavior. An example of this is physically holding a three-year-old child who has suddenly tried to dart into the street.
2. Intervening physically to remove a child from a situation that is so stimulating the child is overwhelmed. An example of this is physically removing a tantruming two-year-old from a supermarket floor to the quiet of the car.
3. Appropriately using standard, industry approved infant and child safety restraints. Some examples include car seats, high chairs with safety belts, toddler harnesses and toddler safety gates.
4. Following steps outlined in an alternative behavior management plan for developmentally disabled children when a separate plan has been developed.

IV.B. Interventions Which Are Prohibited

The following interventions are prohibited in *all* licensed homes and facilities:

1. Corporal punishment of any kind. Examples of corporal punishment include but are not limited to: spanking with a hand or object, biting, jerking, kicking, shaking, pulling hair or throwing the child;
2. Behavioral control methods that interfere with the child's right to humane care. Examples of methods which interfere with humane care include but are not limited to: deprivation of sleep, withholding personal hygiene privileges, providing inadequate food, purposely inflicting pain as a punishment, name-calling or using derogatory comments, verbal abuse, or actions intended to humiliate;
3. Depriving a child of the components of humane care. Examples of the components of humane care include but are not limited to: necessary clothing, adequate shelter, adequate food, and necessary medical or dental care;
4. Depriving the child of necessary services. Examples of necessary services include but are not limited to: contact with the assigned social worker, contact

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

with the assigned legal representative, family contacts and/or therapeutic activities which are part of the child's DCFS Individual Service and Safety Plan (ISSP);

5. Use of medication in an amount or frequency other than that which has been prescribed by a physician or psychiatrist;
6. Giving medications which have been prescribed for another person;
7. Physically locking doors or windows in a way that would prohibit a child from exiting except as described in section VII. E, De-escalation Room with Spring Lock on Door, and section VIII, Secure Crisis Residential Centers.
8. Physical restraint techniques that restrict breathing or intentionally inflict pain as a strategy for behavior control;
9. Mechanical restraints used as a punishment. See section VII. F, Use of Mechanical Restraints for Safety Reasons Related to Disability or Medical Condition, for description of allowed use of mechanical restraints; and
10. Any activity that interferes with the child's basic right to care, protection, safety and security.

IV.C. Licensed Facility Reporting Requirements

Any incident which meets the reporting requirements established by the Division of Licensed Resources (DLR) for licensed facilities (*foster homes, group homes or other residential facility*) must be reported to Children's Administration Intake. The reporting requirements are published in the Children's Administration Practices and Procedures Guide and are available from your licensor or the child's social worker.

V. LEAST RESTRICTIVE INTERVENTIONS

Out-of-home care providers must use the least restrictive procedure that adequately protects the child, other persons or property. Potentially dangerous situations may often be defused if the care provider is alert, intervenes early to change the environment if appropriate, and uses active listening and de-escalation techniques.

Less restrictive interventions must be tried before more restrictive interventions are used unless there is serious threat in injury to the child or others, or serious

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

property damage. Less restrictive interventions may be repeated many times to allow opportunities for learning to occur and the behavior to change.

V.A. Selecting A Behavior Management Strategy

Care providers must be able to select a behavior management strategy or approach that is appropriate for the child, the behavior and the setting. In order to select an effective response that is appropriate to the level of risk posed by the behavior, care providers must understand the following behavior management concepts:

1. Challenging behavior may be an indication of the child's need for greater positive adult support and attention;
2. A child may break rules in a premature effort to assume responsibility rather than in defiance of adult authority;
3. Adults may still provide effective guidance when they:
 - a) Allow the child to make mistakes as part of the learning process;
 - b) Occasionally ignore behavior; and
 - c) Allow the child to learn by experiencing the natural consequences of the behavior (*Allowing natural consequences to occur is not an appropriate strategy if the consequence poses additional risk to the child. For example, it would not be appropriate to let a youth walk home at 10:00 PM because the child spent his or her bus money.*);
4. Positive activities such as shooting hoops or journal writing can help children redirect excess energy or anger;
5. Challenging behaviors can often be redirected through the use of active listening and verbal de-escalation techniques;
6. Early intervention with risky behaviors may be necessary to prevent further acting out and reduce risk of harm to the child or others;
7. All behavior change strategies selected must be appropriate to the child's ability to understand; and
8. Greater objectivity and effectiveness may be gained by consulting with other team members in selecting a strategy.

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

V.B. Giving Consequences as a Response to Inappropriate Behavior

This section applies to all licensed out-of-home care providers. Giving a child a consequence for inappropriate behavior is considered a “less restrictive” intervention. The types of consequences used by the care provider should be discussed with the child before use, whenever possible. All care providers are encouraged to obtain training in general behavior management strategies. Developmentally disabled clients may require a different approach or strategy than those described below. Consult with the DDD worker as appropriate.

1. Care providers may assign consequences for inappropriate behavior.
2. When consequences are used, they must be discussed with the child in such a way that they help the child gain self-control skills and encourage the child to make positive behavior choices.
3. The assigned consequence must not pose additional risk to the child. (*For example, a provider may not make a child spend the night outside because the child came home after curfew.*)
4. Care providers assigning a consequence must keep in mind the child’s unique circumstances, age, developmental level, and cognitive abilities; and
5. If the chosen consequence isn’t working adjust it quickly. Do not give up on the behavior plan. Find consequences that are effective.
6. Examples of permitted consequences include:
 - a) Allowing events to occur which are a natural (*or logical*) outcome of the behavior as long as the child is not unsafe;
 - b) Time-out (*briefly sending the child to a common area such as a bedroom or a special chair in the living room; generally, one minute for each year of age.*);
 - c) Meetings to discuss the behavior and strategies for change;
 - d) Extra chores appropriate for the child’s age and abilities;
 - e) Loss of privileges such as television or telephone;
 - f) Early bed time/early curfew;
 - g) Time limited restriction from planned recreational activities;
 - h) Restricted access to areas generally available to the children in care;
 - i) Increased adult supervision;
 - j) Temporary removal of personal property used (*or threatened to be used*) by the child to inflict injury on self or others;
 - k) Restricting the child from possessing certain items; and

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

- l) Searches of personal property for restricted items.

VI. PERMITTED RESTRICTIVE STRATEGIES

It is expected that care providers will work cooperatively, as part of a team, with social workers and other concerned adults to develop appropriate plans for management of a child's behaviors. More information on this expectation is contained in Section II, General Expectations for Care Providers, and Section III, General Expectations for Social Workers.

VI.A. Restrictive Strategies Permitted in Residential Facilities

1. Specialized training is **required** before a restrictive strategy may be used in a group home or other residential facility. Each child care staff using a restrictive strategy must have completed orientation to the agency's discipline policy and procedures and a general behavior management training which addresses the concepts described in Section V. Least Restrictive Interventions. In addition, the child care staff must have received specialized training in the technique being used.
2. Restrictive behavior management strategies permitted in group homes and other residential facilities include:
 - a) Use of an unlocked special time-out room as described in Section VII.A, Special Timeout Room;
 - b) Use of an unlocked de-escalation room as described in section VII.D, De-escalation Room in Residential Setting;
 - c) Physical restraint as described in Section VII.B, Physical Restraint; and
 - d) Mechanical restraint only for safety purposes as described in Section VII.F, Use of Mechanical Restraint for Safety Reasons Related to Disability or Medical Condition.
 - e) De-escalation room with spring or gravity lock on the door as described in Section VII.E, De-escalation Room with Spring or Gravity Lock.
3. A de-escalation room with a spring or gravity lock on the door may be used in limited residential care facilities which have obtained a license waiver from DLR and which have an on-going training program in appropriate use of this specialized device. DLR may withdraw permission to use the spring locks if DLR has evidence the device is being used inappropriately.
 - a) A spring or gravity locking device requires continuous personal pressure from a staff person to engage the device. Without personal pressure, the device rests in the open, unlocked position.

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

- b) Application process and conditions for use of a spring or gravity locking device are further described in section VII.E, De-escalation Room with Spring Lock on Door.

VI.B. Training Required Before Using Restrictive Strategies

Before a care provider can use a restrictive behavior management strategy, the provider must have received general training in behavior management and specific training in how to use the strategy being applied. Behavior management training must be documented and available for review and comment by DSHS staff.

1. **General** behavior management training must address the following topics at a minimum:
 - a) Recognizing events that could contribute to a crisis;
 - b) Assessing the physical environment;
 - c) Assessing personal response to challenging behaviors;
 - d) Verbal and non-verbal de-escalation strategies;
 - e) Selecting an intervention strategy appropriate to the situation;
 - f) Debriefing the incident with the child and other adults; and
 - g) Incorporating knowledge gained into the service plan or treatment plan.
2. In order to adequately cover the topics listed above, general behavior management training should be no less than eight hours.
3. **Specialized** training must contain discussion of issues and instruction on procedures that are associated with the specific restrictive technique. For each restrictive technique, it is appropriate to receive a minimum of four to eight hours of specialized instruction.
4. Specialized instruction on a restrictive technique must address the following at a minimum:
 - a) Balancing child safety with temporary loss of freedom due to use of the restrictive technique;
 - b) How to appropriately apply the restrictive technique;
 - c) How to monitor and document use of the restrictive technique;
 - d) Assessing when to end use of the restrictive procedure;
 - e) Training and instruction strategies for the child which may reduce the need to use the restrictive technique; and
 - f) Incorporating information gained into the child's service plan or treatment plan.

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

VII. PROCEDURES FOR USE OF RESTRICTIVE INTERVENTIONS

VII.A. Special Timeout Room

A *special* timeout room which is located away from the activities of daily life may be used either as a consequence for poor behavior or to help a child gain behavioral control. ***This is a room separate from the child's bedroom or other living space.***

1. The purpose of time out is to provide the child with some time to think and some distance from a difficult situation. Adults must explain to the child why a time out was given and must help the child consider more appropriate ways to manage similar situations.
2. Generally, when a young child is given a time out, it is appropriate for the child to spend one minute in time out per each year in age. This expectation should be individually adjusted as needed to match the developmental age and safety needs for youth in residential care. The guidelines in #3 below are requirements for all residential settings.
3. A *special* time-out room:
 - a) May not have a locking device of any type on the door;
 - b) Must meet the MLR for a single bedroom including lighting, heating, ventilation and adequate size;
 - c) Must be designed so the child is visible while in the room;
 - d) Must have a comfortable atmosphere;
 - e) May be used only for brief amounts of time. Any period of time longer than 30 minutes requires written approval by the program director;
 - f) Must not allow any child to remain in isolation for more than four hours in a 24-hour period;
 - g) Requires a staff person to visually observe the child at least once in every 15-minutes;
 - h) Requires a child be protected from any means of self-harm;
 - i) Requires documentation of the length of time and reason the child was placed in the timeout room; and
 - j) May be used for only one child at a time.
4. DLR must be notified that a special time-out room is planned and they must have the opportunity to physically inspect the space for appropriateness. DLR will also need to review the program/ facilities record keeping and documentation procedures and logs for the use of the special timeout room.

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

VII.B. Physical Restraint

If physical restraint is necessary, it should be used primarily as part of a treatment and intervention plan for a child with identified behavior management difficulties.

1. Physical restraint may be used only to prevent a child from:
 - a) Seriously injuring self or others;
 - b) Carrying out a believable threat to seriously injure self or others;
 - c) Seriously damaging property; or
 - d) Harm when needing to move them to a less risky location.
2. Efforts to redirect or de-escalate the situation must be attempted before using a physical restraint unless the child's behavior poses an immediate risk to physical safety.
3. Physical restraint may not be used as a form of punishment.
4. Physical restraint techniques which restrict breathing or which intentionally inflict pain as a strategy for behavior control are prohibited.
5. Physical restraint may be used only for a short time to provide the physical control that the child is unwilling or unable to provide for himself or herself. When the child verbally or non-verbally demonstrates an ability to control his or her behavior, the restraint is to be ended.
6. If escalated behavior persists, other options such as use of a timeout room or de-escalation room should be considered. Psychiatric hospitalization or police involvement should be considered if the child's presentation and behavior appear to meet the criteria for involvement by those resources.
7. Children being restrained must be continually monitored, ideally by someone not involved in the restraint, to ensure the child's health and safety.
8. Residential care staff should follow their internal agency documentation policies.
9. Each use of physical restraint must be documented in writing. At a minimum, the documentation must record:
 - a) The child's name and age;
 - b) The date of the restraint;

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

- c) The time in and time out of the restraint;
- d) The events preceding the behavior which lead to use of the restraint;
- e) The de-escalation strategies that were used;
- f) Names of those involved in the restraint and any observers;
- g) A description of the restraint;
- h) A description of any injuries to the child, other children or caregivers;
- i) An analysis of how the restraint might have been avoided; and
- j) Signature of report author.

VII.C. Emergency Use of Physical Restraint

Some children placed in out-of-home care by Children's Administration will demonstrate behaviors which were not expected and which the provider is not specifically trained to manage.

1. If a child's behavior presents an immediate risk of serious harm to the child or others or presents a serious threat to property, a physical restraint may be used *in these emergency situations* to ensure safety even if the care provider has not received specialized training in this procedure.
2. The least restrictive procedure that will provide adequate protection must be used and it must be ended as soon as the need for protection is over.
3. Physical restraint techniques that inhibit breathing or intentionally inflict pain for behavior control purposes are prohibited.
4. A report describing the restraint must be written by the care provider and mailed or delivered to the DCFS social worker and DLR facility licenser within 48 hours of each use of an emergency physical restraint. The report must identify the child and the provider and describe the events leading to use of the emergency restraint, the persons involved, the type of restraint used, whether there were any injuries and how the incident was resolved.
5. When an emergency physical restraint has been used on a child, the care provider/program director and social worker must consult about:
 - a) Immediate strategies for behavior management;
 - b) Whether the service plan adequately identifies and meets the needs of the child; and
 - c) Whether the child will remain in the current placement.

APPENDIX D BEHAVIOR MANAGEMENT GUIDELINES

6. If the child remains in the current placement, the care provider must obtain general and specialized behavior management training within three months. This training would include the appropriate use of restraints.

VII.D. De-escalation Room in Residential Treatment Facilities

Some children may demonstrate an inability to regain control of their behavior in a setting that contains stimulation. These children may require the use of a de-escalation room to assist them in regaining behavioral control.

1. This restrictive intervention is available only in licensed group homes that have policies and procedures in place which ensure:
 - a) Each child in care has a behavior management plan;
 - b) Residential care staff are trained in appropriate use of a de-escalation room;
 - c) Clinical treatment staff are involved in decisions about use of the de-escalation room; and
 - d) Clinical and management staff regularly analyze whether this strategy is being used appropriately.
2. A de-escalation room may be used only when necessary to prevent a child from:
 - a) Inflicting immediate, serious injury to self or others;
 - b) Carrying out a believable threat to inflict serious injury to self or others;
 - c) Seriously damaging property; or
 - d) Continuing to escalate because of environmental stimuli.
3. A de-escalation room:
 - a) Must be barrier free and suicide resistant;
 - b) Must meet the MLR for size of a single bedroom (*80 square feet.*);
 - c) Must have ventilation, heating and lighting. A dimmer switch is permitted to soften (*but not eliminate*) the amount of light;
 - d) Must be designed so the child is visible while in the room;
 - e) May not have a mechanical locking device which remains locked when unattended.
 - f) Must be used with only one child at a time;
 - g) May be used only for brief amounts of time. Any period of time longer than 30 minutes requires written approval by the program director;
 - h) Requires approval of physician for any amount of time over two hours; and
 - i) Does not allow a person to remain in isolation for more than four hours in a 24-hour period.

APPENDIX D

BEHAVIOR MANAGEMENT GUIDELINES

4. ***Appropriate use:*** A de-escalation room may not be used as a form of punishment. It may be used temporarily to provide only that degree of physical isolation that is needed to allow the child to regain control of her behavior. When the child verbally or non-verbally demonstrates an ability to manage her behavior, de-escalation room use is to be ended.
5. When the de-escalation room is occupied, a staff person must be close by, within hearing distance, at all times. A staff person must visually observe the child on a non-predictable schedule. The frequency of visual checks should relate directly to the risk behaviors demonstrated by the child. There must be no more than 15 minutes between visual observations. This observation schedule must be documented.
6. Efforts to counsel and calm the child must be conducted periodically and in all instances before 60 minutes has passed. These interventions must be documented.
7. De-escalation room use may be ended at any time the child demonstrates he or she is ready. An evaluation of whether this intervention is still needed must be conducted within 60 minutes after a child is placed in a de-escalation room.
8. If the child continues to demonstrate behavior which is a serious threat to self, others or property, staff must use agency policies and procedures to obtain clinical and management guidance on appropriate next steps.
9. Each de-escalation room use must be documented in writing. At a minimum, the documentation must record:
 - a) The child's name and age;
 - b) The date of the de-escalation room use;
 - c) The time in and time out of de-escalation room;
 - d) Names of adults and other children involved in the incident;
 - e) The events preceding the behavior that lead to use of the de-escalation room;
 - f) The de-escalation strategies that were used;
 - g) A description of the incident;
 - h) A description of any injuries to the child, other children, or staff;
 - i) Visual observations made while the child is in the de-escalation room;
 - j) The outcome of the de-escalation room use;
 - k) Any revisions recommended to the child's behavior management plan;
 - l) Signature of report author; and
 - m) Supervisory and management signatures per agency policy.

APPENDIX D BEHAVIOR MANAGEMENT GUIDELINES

VII.E. De-escalation Room with Spring or Gravity Lock on Door

A spring or gravity lock requires continuous personal pressure from a staff person to engage the lock. Without personal pressure, the device rests in the open, unlocked position.

1. Spring locks are an additional restrictive measure that may be used only in limited residential care facilities that have obtained a written license waiver from DLR.
2. All the procedures for use of a de-escalation room described in VI.C, De-escalation Room in Residential Treatment Facilities, apply to use of these locks.
3. The spring lock on a de-escalation room door may be engaged only to assist in the behavioral control of youth that are large enough or aggressive enough that injury to the youth or staff is likely without use of the spring lock.
4. Staff must document each time the spring lock is engaged and released during the course of an incident.
5. Residential facilities that would like to develop this option for behavior management must hold a current group home license or equivalent. The facilities must be currently accredited by a national organization such as the Council on Accreditation of Services for Families and Children (COA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
6. Prior to use of a spring lock, the residential facility must apply to the regional office of the Division of Licensed Resources. The application must include:
 - a) A letter of intent;
 - b) A copy of their certificate of accreditation;
 - c) Copies of their policies and procedures relevant to behavior management and use of the de-escalation room with and without the locking device;
 - d) Copies of their staff training plan, incident documentation procedures and incident debriefing procedures; and
 - e) Quality assurance plans related to review of the use of all restrictive interventions including a spring-lock.
7. A review team will be designated to evaluate the application for both the need for a facility with capacity for this restrictive intervention and the appropriateness of the plans submitted. The team will consist of regional staff

APPENDIX D BEHAVIOR MANAGEMENT GUIDELINES

from DLR and DCFS, as well as state office staff from DLR and the Division of Program and Policy Development.

8. The review team will deliver their recommendations to the DCFS Regional Administrator, the DLR Regional Manager, the CA Director of Licensed Resources, and the CA Director of Program and Policy Development. The joint management team will determine whether to approve the application. If the application is approved, DLR will issue a waiver to the license. If the application is denied, a letter explaining the decision will be issued by DLR.
9. Any waiver to the license must be renewed as established by DLR policy.

VII.F. Use of Mechanical Restraints for Safety Reasons Related To Disability or Medical Condition

A mechanical restraint is any object or device that is applied to the child to limit movement. Some developmentally disabled or medically fragile children may require mechanical devices to assist them with body positioning or to reduce opportunities for self-injury or wandering.

1. The following assistance devices are excluded:
 - a) Age appropriate, infant and toddler safety devices;
 - b) Orthopedic braces;
 - c) Automobile and wheelchair safety belts.
2. Mechanical restraint for punishment purposes is prohibited in all licensed out-of-home care settings.
3. Mechanical restraint for safety purposes is permitted only when DLR has given the care provider a written waiver to the license that authorizes the provider to use a specific mechanical restraint for a specific child. These waivers are time limited and must be renewed.
4. Before using a mechanical restraint, the out-of-home care provider, social worker and health care provider must weigh the child's right to freedom of movement against the potential for injury to the child if the restraint is not used.
5. When a mechanical restraint is being used with a child, the out-of-home care provider, social worker, physician (*or designee*) and other adults responsible for the child must regularly engage in discussions about whether the restraint is still needed. Also to be considered is whether there are other less restrictive

APPENDIX D BEHAVIOR MANAGEMENT GUIDELINES

methods that could benefit the child. This consideration of other options must be documented by the social worker as part of the quarterly health and safety contact.

6. Prior to the use of any mechanical restraint, there must be a medical order, signed by the child's physician, for this intervention. The medical order must:
 - a) Describe the specific restraint to be used and the circumstances in which it is to be used;
 - b) Identify the caregiver skills and knowledge needed to apply the restraint correctly; and
 - c) Suggest strategies for intervention that might reduce future need for use of the mechanical restraint.
7. An out-of-home care provider who has received a waiver to utilize a mechanical restraint must obtain training in the safe and appropriate use of the restraint in their setting. Any substitute or respite care providers must also be trained in safe and appropriate use of the restraint device.
8. A building evacuation plan must be written that clearly states who will be responsible for evacuating each restrained child in an emergency. When substitute care providers are on duty they must be informed of the building evacuation plan and which children they will be responsible for in the event of an emergency.

VIII. SECURE CRISIS RESIDENTIAL CENTERS

Only Secure Crisis Residential Centers are authorized to have exterior door and window locks that restrict exit from the building, and to have secure perimeter fencing. Locked confinement within a Secure Crisis Residential Center or other licensed out-of-home care facility is not permitted.