# Outline of Considerations for Training Relative to a Model of Service for Challenging Behavior

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The Autism Speaks Thought Leadership Summit on Challenging Behaviors, held in December 2020, convened leaders in autism care and research across North America. The Summit aimed to characterize the landscape of services and supports for people with autism with challenging behavior and acted as a catalyst for innovations in programs and policies to improve systems of care for this population. Six workgroups were formed, utilizing Summit participants, to develop recommendations and priorities related to both practice and public policy.

The following document covers the topic of essential training and safety policies and procedures necessary for providing services to those with severe challenging behavior, a need identified by Summit leaders and participants, to better understand what is currently known about outcomes for autistic individuals with severe challenging behaviors, and which practices, programs, and policies have demonstrated impacts; what existing or new mechanism can help in scaling up such efforts; and what potential opportunities exist to enhance capacities in systems supporting services to aid in scaling-up or improving quality of implementation in this topical area.

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For more resources and information, visit www.autismspeaks.org/clinician-guide-program-development-best-practices.

## How to Cite this Document

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## Executive Summary

Children and adults with autism spectrum disorders (ASD) and intellectual and developmental disabilities are at increased risk to engage in challenging behavior such as self-injury, aggression, and destructive behavior. These problems vary widely in terms of their severity and their responsiveness to treatment. In some cases, these problems pose little risk and are responsive to treatment. For those with the most severe and treatment-resistant problems, the risks of harm to self and others can be significant. These individuals experience frequent crises, their families are under great stress, and they are at great risk for injury and placement outside the home and expulsion from school. Fortunately, research shows that such challenging behaviors can be effectively treated in most cases through the use of behavioral interventions as well as medication, when indicated. In cases where first-line individualized interventions are insufficient, and the behaviors of concern are immediately dangerous, more intensive treatment services are sometimes needed. Addressing the problem of challenging behavior in individuals with ASD requires that programs: a) develop and implement policies that support best practices and provide sufficient resources to meet the needs of these individuals; b) ensure professional staff with clinical decision-making authority are qualified by training and experience, and licensed/certified to provide such services; c) ensure clients' and caregivers' needs are met by making referrals to other providers when appropriate; and, d) provide training to direct-care staff to ensure knowledge of professional ethics, rights of clients, competency about ASD, cultural responsiveness, and possess specific skills for the management of severe challenging behavior. Training must be ongoing, and formal methods of assessing and monitoring competencies must be applied regularly and reported to senior clinical staff and senior management of the organization. It is important for programs providing intensive services to distinguish between behavior management techniques implemented within treatment and those utilized for short-term crisis management. The use of management techniques requires informed consent, that the intervention is professionally prescribed by an individual qualified by training and experience, applied in a manner that is consistent with best practices, implemented by sufficiently trained staff with documented competency, and monitored to ensure safety, and its reduction and elimination if possible. The purpose of this

document is to provide an overview of the considerations relative to training personnel who develop and deliver service to autistic persons who present with challenging behavior.

## A. Review of the current literature.

**Challenging Behavior.** Individuals with ASD and/or intellectual disabilities (ID) are at increased risk to engage in challenging behavior [1, 2], which poses risks to self or others and is disruptive to functioning. This includes self-injurious behavior (SIB; e.g., head banging, skin picking, self-biting, and head hitting), aggression towards others (e.g., hitting, kicking, biting, and scratching others), pica (i.e., the ingestion of nonnutritive substances), disruptive behavior (e.g., destroying property and throwing items), and elopement (i.e., leaving the presence of a caregiver outside of appropriate contexts), among others. Challenging behavior among individuals with ASD is multifaceted and presents as a heterogeneous phenomenon. Some individuals may present with only one form of challenging behavior (e.g., aggression), whereas others may engage in multiple forms (e.g., aggression, elopement, self-injury, pica). These challenging behaviors sometimes co-occur with irritability, generally defined as outbursts expressive of anger, frustration, and distress [3]. Challenging behavior can be relatively mild and transient in some individuals, or highly severe, treatment resistant, and chronic in others. The pattern of occurrence can be episodic or near constant, and it can range from a few occurrences per week to hundreds of occurrences per day.

**Phenomenology.** Challenging behavior can occur in as many as half of individuals with ID [4]; and 5–10% of these individuals' behavioral challenges are characterized as severe [5]. The prevalence of SIB among children with ASD is reported to exceed 28% [6]. Elopement also puts a child at risk for serious harm or death; and one recent parent survey indicated that 49% of children with ASD engaged in elopement after the age of 4 years [7]. Among those that reported one or more instances of elopement, nearly one quarter were in danger of drowning, and over two-thirds were at risk of being struck by a motor vehicle. Like findings on other forms of challenging behavior, the severity of the child's disability was associated with higher rates of elopement.

**Impact.** Challenging behavior can pose risks to self and others. **Self-injury** can cause localized swelling, bruising and bleeding, loss of tissue from tongue, lips, ears and nose, blindness from retinal detachment, and permanent disfigurement. **Aggressive and disruptive** behaviors can result in severe injuries to family members and care providers. **Pica** can cause poisoning, death, and/or necessitate surgery. **Elopement** can result in injury or death. In addition to injuries, challenging behavior can result in a diminished quality of life for the individual, limited access to community resources, and necessitate a myriad of costly resources to manage the resulting circumstances produced by challenging behavior [8, 9].

The negative impact of challenging behavior on the family unit is significant as well. In the case of individuals with ASD who exhibit aggressive behavior, daily routines are regularly disrupted, well-being of family members is compromised (e.g., caregivers report a high level of stress, and feeling isolated) [19, 20], and financial resources are exhausted on extra supports, medical visits and care, crisis-related expenses, etc. Paradoxically, families with a child who has ASD and exhibits aggressive behavior have a difficult time accessing educational services and supports specific to the treatment of aggression [21]. Given this, there is a need to provide resources for families as well as those with an ASD diagnosis so they can effectively advocate for and access these education and clinical services.

## B. Risks/Benefits analysis

When encountering challenging behavior, it is important for clinicians to evaluate the risks presented by each type of problem behavior as part of the process for determining the best course of action. Mild challenging behavior, though it might not be harmful to the individual, can become moderate to severe and early intervention may prevent this progression. When problem behavior reaches crisis levels it can pose immediate risks to the individual and others and necessitate crisis management procedures. It is important to identify and weigh the risks of intervening in a crisis situation to employ crisis management, relative to the risks of not employing crisis management. In these contexts, great care must be taken to mitigate risks associated with the use of crisis management procedures. As noted elsewhere in this document, safeguards are necessary to ensure crisis management procedures are used appropriately and

only when necessary (see **Safeguards** below). There are also risks associated with assessment and treatment in terms of resources needed to develop effective intervention. Therefore, it is necessary to evaluate the risks of problem behavior in the context of both the risks and benefits of assessment and intervention. Additionally, even with mild challenging behavior, consideration should be given to developing a crisis management plan. (Extensive guidance on evaluating the risks and benefits of assessing and treating challenging behavior and implementing crisis management is provided in Appendix A.

**C. Interventions.** While relatively minor challenging behaviors can often be treated in educational settings or with simple behavior plans, more severe and treatment-resistant problems often require specialized resources. This includes intensive behavioral interventions and/or the use of medications. Oftentimes, pediatricians are the first professionals to encounter an individual's challenging behavior. These primary care providers are positioned to initiate the process of assessing the individual's immediate and longer-term care needs [3]. It is essential that individuals with more severe problems access the services of professionals who are qualified by training and experience, and licensed/certified to provide such services. These services may include assessment by a speech language pathologist to identify functional communication needs, assessment by a behavioral service provider to identify the function or cause of challenging behavior, and a psychiatrist to assess co-occurring psychiatric conditions. It is beyond the scope of this discussion to provide a detailed analysis of how severe challenging behavior should be assessed and treated; however, a summary is provided.

**Best practice behavioral interventions**. Focused treatment using applied behavior analysis (ABA) has a strong base of empirical support. This approach has been extensively researched and is widely recognized as representing best practices for challenging behaviors such as aggression and self-injury in individuals with ASD and Intellectual and Developmental Disabilities (IDD). The cornerstone of focused treatment for challenging behavior using ABA relies on functional behavioral assessment, which can identify the events that trigger and strengthen challenging behavior. Assessment findings are then used as the basis for developing highly individualized treatments aimed at changing those situations that

occasion the behavior and establishing new patterns of appropriate behavior using reinforcement. This approach to behavioral treatment is consistent with the principle of minimal restrictiveness because more intensive procedures are only used when lesser intensive ones have failed or are determined to be insufficient [22, 23, 24]. These behavior analytic interventions have a strong base of empirical support and are widely recognized as representing best practices.

In cases where first-line individualized interventions have failed, and the behaviors of concern are immediately dangerous, more intensive treatment services are sometimes needed. In cases with the most severe behavior, it may be necessary to use physical management techniques at times: this includes momentary response interruption (e.g., momentarily placing one's hand or padding between the child's hand and face in the case of face hitting), or brief safety holds (e.g., holding the child's hands for 30 seconds) to interrupt the behavior of concern; and, in rare cases where the risks of injury are extreme (such as head banging on a hard surface or continuous face slapping, eye gouging, or skin scratching directed at existing wounds), the use of protective devices may be needed to avoid permanent injury. The use and considerations for such procedures and devices has been discussed elsewhere [22, 23, 24, 25] and should be carefully weighed relative to concerns raised by their use. Protective devices used for this purpose include dressings over wounds, gloves, and padded helmets that protect the child from head lacerations, concussions, or retinal injury [26]. In the most severe cases, devices such as arm splints may be needed to limit elbow flexion to prevent severe face scratching, head hitting, eye poking, or hand-biting [27, 28]. The published literature shows physical management techniques, protective equipment, and arm splints can be applied in the context of treatment to produce positive outcomes [29-31]. The use of prolonged restraint (prone or supine) and prolonged seclusion has not been studied or reported in the literature. More research and access to proactive intervention resources are needed.

**Distinguishing between management and treatment**. When discussing severe challenging behavior, it is important to distinguish between *management* techniques and *treatment*. ***Management*** refers to techniques focused on preventing challenging behavior and includes a variety of procedures such

as decreasing instruction time, interrupting challenging behavior, and the use of protective equipment to prevent injury. ***Crisis management*** is a particular type of management that is more reactive and is not used preventatively but only after challenging behavior has escalated to crisis levels that present imminent risk to the individual or others. Both behavior management and crisis management are more short-term oriented and do not necessarily involve the use of individualized treatments. In contrast, ***Assessment and individualized function-based treatment*** refers to proactive interventions, informed by functional behavior assessment, aimed at producing lasting behavior change, including those that prevent or reduce the occurrence of challenging behavior. Treatment is long-term oriented, applying techniques that establish adaptive replacement behaviors, shape tolerance skills, arrange predictable routines, and extinguish old patterns of behavior. This process requires careful assessment and training across many learning trials delivered over a period of weeks and/or months. When developing an individualized treatment, it may be necessary to use management and/or crisis management techniques *temporarily*, but this is only acceptable if done while challenging behavior is being assessed and a treatment is developed. The use of management techniques, particularly crisis management in the absence of efforts to assess and treat challenging behavior does not represent appropriate care [22]. When an effective treatment is applied over time, management procedures can often be reduced to the extent they are used rarely and even eliminated [32-34]. For some individuals with more severe challenging behavior, however, use of both treatment and management techniques may be needed on an ongoing basis to increase safety and allow the individual to participate in school and community life.

**Safeguards on the use of management techniques**. As noted above, the use of management techniques in the absence of treatment is generally not appropriate, except on a temporary basis. Programs serving individuals with challenging behavior should develop policies that clearly describe use of management techniques. Those policies should be consistent with state and federal law and include: a) when specific procedures can and cannot be used; b) prohibited procedures; c) allowable duration of procedures; d) patient education on procedures; and, e) documentation and reporting of procedures.

Management techniques should be described within the individual's plan of care that includes education and positive reinforcement techniques, to be used in a manner consistent with their needs. Management techniques should be: a) used with the informed consent of the client or guardians; b) professionally prescribed by an appropriately credentialed individual qualified by training and experience; c) applied in a manner that is consistent with best practices (is based on research findings, minimally restrictive and in no way physically harmful or abusive); d) implemented by sufficiently trained staff with documented competency; and, e) objectively monitored to ensure safety, and the reduction and elimination of the intervention, if possible.

**Comprehensive assessment of medication use.** In addition to needs for behavioral services, individuals with autism have significant medical needs which can interact with or exacerbate behavioral issues. Pediatric care providers play an essential role in the general identification and management of autism and are particularly critical for directing etiologic testing as well as medical management of co-occurring conditions [35]. As individuals with autism experience medical issues at rates far higher than their neurotypical peers, including gastrointestinal and feeding issues, sleep disturbances, and seizures, both pediatric and behavioral service providers must consider how these problems may contribute to the behavioral dysfunction – and collaborate when indicated. Likewise, cross-discipline collaboration is advisable if problem behavior and non-compliance during medical appointments interfere with essential medical care.

Many primary care providers are equipped to directly provide first-line interventions for problem behavior through parent education and medication management. Models for the targeted use of behavioral and pharmacological interventions have been described [36-38]. It is advisable providers identify risks for injury to self or others, assess caregiver-child interactions to determine what events may occasion and reinforce the behavior, and educate caregivers on optimal management techniques [38-39]. There are currently two FDA-approved medications, aripiprazole and risperidone, for the treatment of irritability, which includes behavioral outbursts, aggression and self-injury. These medications are appropriate to

trial if problem behavior is severe and if other behavioral interventions have failed to produce sufficient improvement or are unavailable. When emotion dysregulation and impulsivity are prominent, appear to occur across contexts, and persist despite behavioral intervention, then medications should be considered – although findings related to efficacy of many agents are mixed [40]. For individuals with more severe, chronic, and treatment-resistant problem behavior, specialized interdisciplinary care involving integrated behavior and pharmacological interventions may be indicated [35, 39].

**A model for providing service.** A description of the specific training procedures for professional and paraprofessional staff is beyond the scope of the current discussion, however, a thorough overview is provided in Appendix C. Programs serving individuals who have severe challenging behavior are responsible for: a) developing and implementing policies that support best practices and provide sufficient resources to meet the needs of these individuals; b) ensuring professional staff with clinical decision-making authority are qualified by training and experience, and licensed/certified to provide such services; c) ensuring clients', students', and caregivers' medical, communicative, psychological, behavioral, and psychiatric needs are addressed by making referrals to other providers when appropriate; and, d) providing training to direct care staff to ensure knowledge of professional ethics, rights of clients, competency about the needs of individuals with autism and intellectual impairments, and the acquisition of specific skills related to management of severe challenging behavior. Training must be ongoing, and formal methods of assessing and monitoring competencies must be applied regularly and reported to senior clinical staff and senior management of the organization.

## Training Recommendations

Challenging behavior such as self-injury, aggression, and destructive behavior is often encountered in children and adults with ASD and IDD. Given that these challenges vary widely in terms of their severity and their responsiveness to treatment, intervention needs to be tailored to the individual and the context in which challenging behavior is occurring. Research suggests that challenging behaviors

can be effectively treated in most cases through the use of behavioral interventions and medication, when indicated (reference/link to best practices group document). Addressing the problem of challenging behavior in individuals with ASD requires programs must: a) develop and implement policies that support evidence-based best practices and provide sufficient resources to meet the needs of these individuals; b) ensure professional staff with clinical decision-making authority are qualified by training and experience, and licensed/certified to provide such services; c) ensure clients' or students' and caregivers' needs are met by making referrals to other providers when appropriate; and, d) provide training to direct staff to ensure knowledge of professional ethics, rights of clients or students, competency about ASD, and possess specific skills related to management of severe challenging behavior. Training must be ongoing, and formal methods of assessing and monitoring competencies must be applied regularly and reported to professional staff and senior executives of the organization. This document focuses on describing recommendations for the policies, trainings, and competencies relevant to a model of effective service delivery for challenging behavior.

**Definitions:**

*Policies* are a set of rules or guidelines for an organization and employees to follow to achieve a specific goal, in this case, addressing challenging behavior. An effective policy should outline what an organization, executive, administrator, professional staff (i.e., clinical supervisors), and/or direct care employees must do or not do and will provide directions, limits, principles, and guidance for decision making. Any organization that provides services to assess, treat, and/or to otherwise manage challenging behavior should develop their own policies with attention to relevant federal, state, and local statutes and regulations. The intention of this document is to serve as a model.

*Trainings* consist of instruction in the skills and knowledge that relate to specific useful competencies in the evaluation, assessment, and intervention of challenging behavior. There are many distinct types of trainings and training modalities. Any organization that provides services to assess, treat, and/or to otherwise manage challenging behavior should develop their own trainings with attention to current

evidence-based practices, relevant federal, state, and local statutes and regulations. Again, the intention of this document is to serve as a model.

*Competency* is the ability to apply or use a set of related skills and knowledge required to successfully perform 'critical work functions' or tasks in the service delivery setting. Competencies can be knowledge based, skills based or both knowledge and skills based. When trainings are developed by an organization, the relevant competencies that should emanate from those trainings should be identified and the trainings should be designed to produce the relevant competencies. Post training evaluations of those competencies is highly recommended.

Competencies are designed to ensure trainees have acquired knowledge and targeted skills. Competencies may take many forms. Written competencies such as worksheets, quizzes or written responses to scenarios assess verbal knowledge, or what someone "knows" about a subject. These types of assessments are easy to deliver and create a permanent record that an employee received a training and met the specific competency. However, written assessments are insufficient to determine if skills will be performed correctly.

Physical competencies evaluate a trainee's performance conducting target skills. Physical competencies should measure all the relevant aspects of a specific skill. For example, is the skill under the appropriate stimulus control (i.e., exhibited when it should be, and not when it shouldn't be)? Is the skill performed in the prescribed manner? Is the skill performed with sufficient, but not excessive, magnitude (e.g., force, volume, etc.)? Are all safety guidelines followed? Is the skill performed fluently? The number of aspects assessed will vary considerably based on the complexity of the target performance, but care should be taken to identify and measure those aspects that most directly relate to desired outcomes.

Physical competencies may be measured using a Likert-type scale or more directly using direct observation techniques. A Likert-type scale is often useful if a skill is demonstrated repeatedly throughout a training and "overall" performance is being assessed. In some cases, trainees may need to

meet specific mastery criteria (e.g., the trainee will conduct a discrete trial procedure correctly in 9 out of 10 opportunities) to pass a competency. The latter types of measurements have the advantage of being more precise but are typically more resource intensive.

Physical competencies are typically assessed in the context of role plays. In general, the role play situation should mimic the actual conditions under which the skill needs to be performed as much as possible. In some cases, individuals may be trained how to implement a particular skill in general, without any modifications that may be appropriate for specific clients. In these situations, providing additional "on the job" training and/or competencies that incorporate modifications for individual clients is highly recommended.

**Procedural integrity.** Even when staff receive comprehensive training in performing a skill or set of skills, supervisors must ensure that the skills are implemented on the job as prescribed. Obstacles to correct implementation of procedures and guidelines include, but are not limited to, insufficient training, a lack of materials and/or resources, insufficient prompts or clarification regarding performance expectations, competing tasks and/or demands, and inconsistent or competing performance consequences. Accordingly, it is imperative that formal and informal systems for monitoring procedural integrity are routinely implemented. Supervisors should assume that training will not be sufficient to ensure that staff implement guidelines and procedures as prescribed. This is because staff face several obstacles in performing their responsibilities, including but not limited to a lack of materials and/or resources, insufficient prompts, competing responsibilities, and competing consequences. Therefore, even when effective training procedures are in place, it is important to regularly assess on the job performances.

The task of assessing procedural integrity across a multitude of skills can seem daunting for resource-strapped schools and agencies. However, the risks of not assessing procedural integrity are potentially significant [41]. For example, first line interventions that are implemented inconsistently may be mistakenly discontinued as ineffective, and more intrusive interventions may be implemented instead. Some suggestions for assessing procedural integrity include implementing procedural integrity checks if

an intervention is not successful, selecting priority skills and implementing procedural integrity checks on a systematic, rotating basis, and using video samples of performances to check procedural integrity. Not all skills need to be assessed at all times. One skill or set of skills can be assessed at a time, and very brief periods (e.g., momentary time-sampling) may be used to measure procedural integrity for that skill. The next day a different skill could be assessed, and so on.

Another obstacle to assessing procedural integrity may be finding someone to observe in a classroom. In these cases, videotaping a staff performing a specific skill and evaluating the performance later may be an option.

**Personnel and Qualifications:**

*Executives* develop the program and establish the aims and scope of the service delivery agency. They oversee administrators and clinical supervisors. Executives receive training and demonstrate relevant competencies specific to their roles in their agencies, but at a minimum, executives need training and/or relevant prior experience with the needs and challenges of the populations they serve.

*Administrators* provide support to the clinical team at the direction of program executives and provide system support for managing day-to-day operations. Administrators receive training and demonstrate relevant competencies outside of any professional credentials they may hold that are relevant to providing care to persons with challenging behavior.

*Professional staff* design and oversee the implementation of clinical programming and receive training and demonstrate relevant competencies outside of any professional credentials they may hold that are relevant to providing care to persons with challenging behavior. They are also responsible for training and providing support to the direct care staff. Professional staff should have training and qualifications relevant to developing and overseeing the provision of behavior management, behavioral interventions, and crisis management. When individuals with severe challenging behavior are receiving clinical and/or educational services, senior professional staff supervisors should direct assessment, intervention, and

management. These professionals should have coursework, training, and appropriate credentialing and/or licensure when required by state or federal law (e.g., Board Certified Behavior Analyst®; Licensed Behavior Analyst; Licensed Psychologist, etc.). Senior clinical supervisors should ideally have a minimum of 5 years' experience in developing, conducting, and overseeing the functional assessment and treatment of challenging behavior. Clinical supervisors that independently oversee the assessment and treatment of challenging behavior should have a minimum of 2 years' experience in developing, conducting, and overseeing the functional assessment and treatment of challenging behavior. Clinical supervisors also receive training and demonstrate relevant competencies outside of their professional credentials.

*Direct care staff* implement clinical programming at the direction of the clinical supervisors. Direct care staff receive training and demonstrate relevant competencies on all assigned responsibilities, for example, collecting data, implementing skill acquisition procedures, implementing behavior management guidelines, reporting procedures, and ethics.

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# Appendix A

## Risk and Benefit Analysis for Treating Problem Behavior

### I. Risk Assessment for Problem Behavior

An assessment of the risks and benefits for treating problem behavior must begin with an assessment of the risks of the problem behavior to the individual and to others. This assessment must weigh the risks of problem behavior across multiple dimensions along with the frequency with which the risks are likely to be incurred. The more severe the impact of the problem behavior, and more frequent it is, the higher the risk. These risks can then be compared to the risks and benefits of treatment.

### Dimensions of Risk Assessment for Problem Behavior

1. **What are the dimensions (types) of the risks of the problem behavior?** *The categories below represent the most relevant dimensions of risks that problem behavior may cause. Every situation is unique - this list is not intended to be a hierarchy of importance nor is it exhaustive.*
    a. **Physical risks** – physical harm to individuals ranging from tissue damage to death.
    b. **Developmental risks** – interference to education and/or vocational activities ranging from no interference to no participation.
    c. **Social risks** – interference with functioning in the family, making friends, participating in community events.
    d. **Autonomy risks** – interference with the individual's ability to make decisions regarding their own life. Special consideration should be given to behaviors that are particularly dangerous or illegal (e.g., sexualized behavior of minors may be treated in certain settings without involving law enforcement, but if this behavior persists it may lead to imprisonment).
    e. **Economical risks**– interference with earning income (e.g., problem behavior interferes with access to work) and risks associated with the problem behavior (e.g., risks of repairing the environment, hiring additional supports, etc.).
    f. **Emotional risks –** the stress and trauma caused by the problem behavior and its related risks can have significant impact on the emotional well-being of the individual and others.

2. **To whom do the risks apply?** *For each category below, identify the severity of the risk as well as the frequency given no treatment or continuation of current treatment*.
    a. **Individual** – the primary focus of this risk assessment is the impact on the individual displaying the problem behavior.
    b. **Family** – the risks to the family must also be a primary consideration in assessing the risk of the problem behavior.
    c. **Peers**
    d. **Caregivers**
    e. **General public**

### Scoring the Assessment

We recommend using the scales below to determine the overall risks of the problem behavior in relation to the risks and benefits of treatment. These scales should be used for each of the dimensions indicated above across each of the categories of people affected by the problem behavior. The more 2's and 3's that

are scored, the higher the risk of the problem behavior and the more likely that it should be treated. When the scoring is complete, it should be used not only to identify if treatment is warranted, and if so, how to treat, but to compare the risks and benefits of the proposed treatment and alternatives.

*Note: It is beyond the scope of our mission to create a more complete and objective scoring system with recommendations based upon scores, although this could be a recommendation for future research.*

**Scale 1. Severity of Problem Behavior**

| | |
|---|---|
| **0** | **Minimal** |
| **1** | Mild |
| **2** | Moderate |
| **3** | Severe |

**Scale 2. Frequency of Problem Behavior**

| | |
|---|---|
| **0** | **Rare (e.g., several times per year)** |
| **1** | Occasional (e.g., several times per month) |
| **2** | Frequent (e.g., several times per week) |
| **3** | Very Frequent (e.g., several times per day or more) |

## I. Outcomes of Assessment for Problem Behavior

The outcomes of the assessment for problem behavior include management, treatment, and crisis management. Although the risks of the problem behavior are critical in determining the next steps, ***context*** and ***culture*** must also be considered. Context includes an evaluation of the current settings and target settings; culture encompasses setting socially valid goals and using culturally informed assessments.

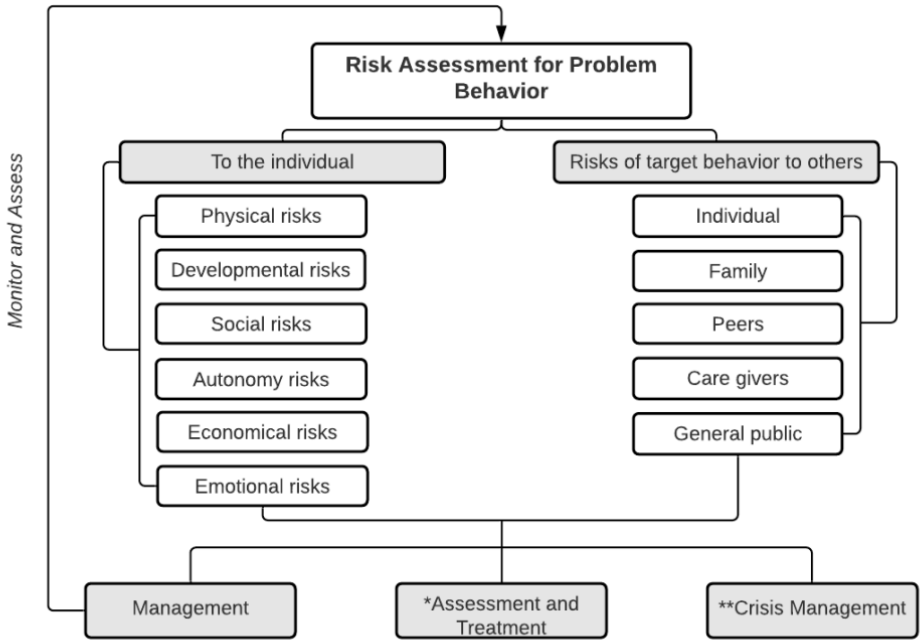
The three general outcomes include:

1. **Management** – the challenging behavior is "managed" by general protocols (e.g., general school rules and procedures, general guidelines for managing types of challenging behavior such as ignore/redirect, etc.).
2. **Assessment and Treatment** – the function of the challenging behavior is assessed and a function-based treatment is designed and implemented. Typically, an appropriate alternative is taught and reinforced.
3. **Crisis Management** – the challenging behavior requires restrictive procedures to ensure the safety of the client and/or others. Restrictive procedures are defined by their absolute levels of restrictiveness, duration, and efficacy. Crisis management may include physical restraint, mechanical restraint, medication (PRN, antipsychotics, etc.), and/or the use of aversive stimulation. The function of crisis management is safety – not treatment.

Note: these outcomes are not mutually exclusive. For example, a behavior that is being treated may also require crisis management techniques. A behavior that is being treated may also be managed in some contexts while assessment and treatment are conducted in other contexts. For this assessment, however, ***management*** as an outcome indicates that the problem behavior does not pose sufficient risks to warrant intervention and is not selected as a socially significant target. As such, the risks of the problem behavior are monitored and periodically assessed. ***Assessment and Treatment*** indicate that the risks of the problem behavior are such that a functional treatment is indicated, and the problem behavior is a socially significant target. Finally, crisis management indicates that safety considerations

require the use of safety techniques. These techniques may be in place at the same time assessments and treatments are implemented, but they do not replace assessment and treatment. We would also argue that if crisis management is the indicated outcome, assessment and treatment must be implemented as soon as possible. A short period of crisis management without assessment and treatment may be justifiable if the time is used to gather the necessary personnel and resources to implement treatment, for example, but an indeterminate period of crisis management is not ethical.

**Figure 1. Risk Assessment of Problem Behavior**




Note: to modify figure as follows: Replace “To the Individual” with “Risk Dimensions” and replace “Risks of target behavior to others” with “Risk Recipients”

## II. Risks and Benefits of Assessment and Treatment of Problem Behavior

In assessing the risks and benefits of Assessment and Treatment, the following steps are recommended.

**Risks of Assessment and Treatment**

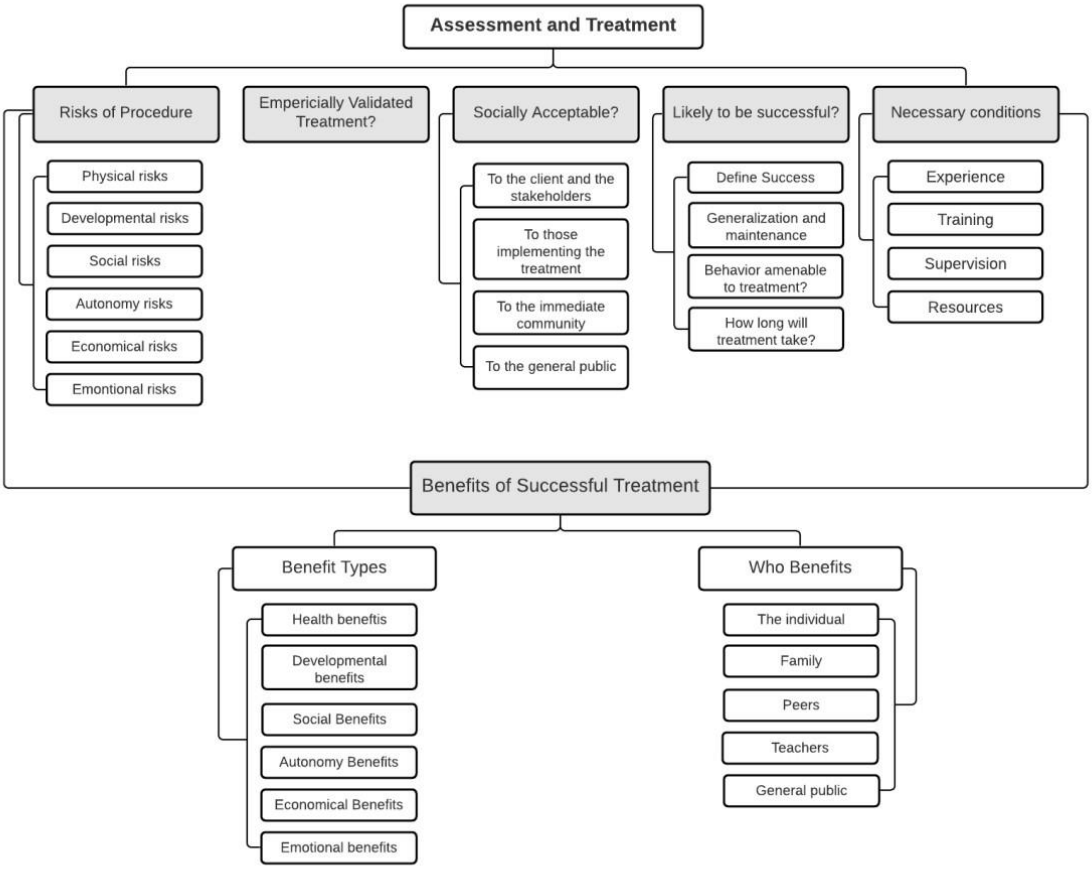
1. What are the risks involved with assessment and treatment? These risks should be considered separately for the assessment procedure(s) and the treatment procedures(s), and the risks should be specific to the procedures themselves (not the impact these procedures may have on the problem behavior). Be sure to consider **unintended consequences** (e.g., emotional responding) and the **potential overuse** of effective procedures. *All risks should be calculated, including risks to the client, stakeholders, those implementing the treatment, and others.*
    a. Physical
    b. Developmental

   c. Social
   d. Autonomy
   e. Economical
   f. Emotional
2. Is the treatment empirically validated?
   a. Empirically validated treatments are the standard
   b. Experimental procedures may be warranted in special cases (e.g., all known relevant empirically validated treatments have been unsuccessful, special safeguards, etc. – expand this section).
3. Is the treatment acceptable/socially valid?
   a. To the client and the stakeholders
   b. To those implementing the treatment
   c. To the immediate community
   d. To the general public
4. Is the treatment likely to be successful?
   a. How is success defined? (e.g., elimination of problem behavior, reduction of problem behavior, replacement of problem behavior with an alternative, etc.)?
   b. Will success be maintained across settings and caregivers? Will success be maintained after the treatment is removed?
   c. Is the behavior typically amenable to the proposed treatment?
   d. How long will it take to be successful?
5. What are the necessary conditions for treatment success?
   a. Experience
   b. Training
   c. Supervision
   d. Resources

Benefits of Successful Treatment

1. Benefit Types
   a. Health
   b. Developmental
   c. Social
   d. Autonomy
   e. Economical
   f. Emotional
2. Who Benefits?
   a. Individual – Primary consideration
   b. Family
   c. Peers
   d. Teachers
   e. General Public

Note – the risks weighed in this assessment refer to the risks of the procedures, as the risks of the problem behavior have already been determined. The risks of the procedures are then weighed against the benefits – that is, the reduction of risks of the problem behavior expected from a successful treatment.




## III. Risks and Benefits of Crisis Management

In assessing the risks and benefits of Crisis Management, the following steps are recommended.

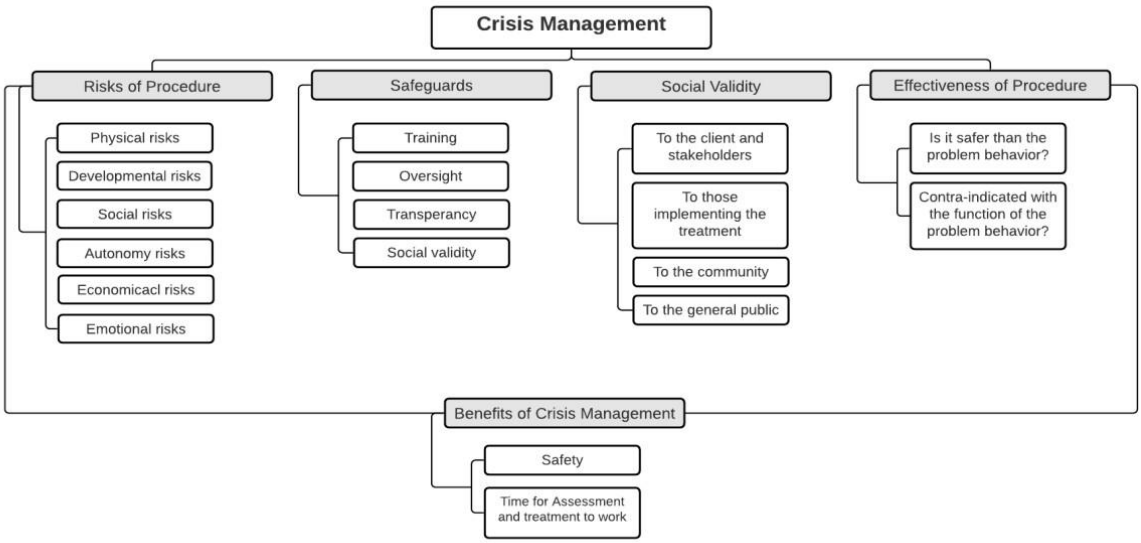
Risks of Crisis Management

1. What are the risks involved with crisis management? These risks should be considered separately for different types of procedure(s), and the risks should be specific to the procedures themselves (not the impact these procedures may have on the problem behavior). Be sure to consider **unintended consequences** (e.g., emotional responding, medication side effects, etc.) and the **potential overuse** of procedures.
    a. Physical
    b. Developmental
    c. Social
    d. Autonomy
    e. Economical
    f. Emotional
2. Safeguard
    a. Training
    b. Oversight
    c. Transparency

   d. Social Validity
3. Is the crisis prevention procedure acceptable/socially valid?
   a. To the client and the stakeholders
   b. To those implementing the treatment
   c. To the immediate community
   d. To the general public
4. Is the procedure likely to be effective?
   a. Safer than the problem behavior?
   b. Is it contra-indicated with the function of the problem behavior?

Benefits of Crisis Management

1. Safety of individual, others
2. Time for assessments to be conducted and/or treatment to be successful



## Appendix B

### Recommended Policies for Behavioral Treatment and Crisis Management

### Behavioral Treatment Policy (BT)

1. Guiding Principles for Behavioral Treatment for Challenging Behavior. Behavioral Treatment refers to interventions aimed at producing lasting behavior change, including those that prevent or reduce the occurrence of challenging behavior. Behavioral interventions should be applied in a manner consistent with established ethical guidelines, and in accordance with best practices. Treatment plans should be developed in collaboration with caregivers, individualized, minimally restrictive, based on assessment findings, and developed and implemented by appropriately trained and credentialed professional staff. Behavior management procedures may be needed in some cases (see 2.6 below). For clients or students with challenging behavior, crisis management procedures may be needed as well. Behavioral treatment is long-term oriented and requires interventions delivered over a period of weeks to months or longer. In contrast to behavioral treatment, crisis management techniques are more short-term oriented and focused on preventing injury in the context of a behavioral crisis (see Crisis Management Policies below). These additional techniques should always be applied in combination with behavioral treatment.

2. Recommended Policies for the Development, Application, and Monitoring of Behavioral Treatment
   Organizations should develop policies to ensure behavioral treatments are applied in accordance with the guiding principles described above. Organizations should hire qualified professional staff and develop and provide knowledge and skill-based training to direct care staff working with clients or students to ensure competency. Policies should ensure that:
   - 1.1 Professional staff who are responsible for developing behavioral treatment plans are qualified by training and experience
     - 1.1.1 The organization ensures professional staff with clinical decision-making authority are qualified by formal training and experience to assess and treat challenging behavior
     - 1.1.2 Professional staff should be appropriately credentialed and/or licensed
   - 1.2 Direct care staff responsible for implementing behavioral procedures are regularly trained, and their competency is documented. The organization provides supervision, oversight, and training to staff who implement behavioral interventions with clients or students to ensure:
     - 1.2.1 Knowledge of professional ethics
     - 1.2.2 Knowledge of rights of clients and/or students

1.2.3 Competency about the needs of individuals with Autism and intellectual or developmental disabilities

1.2.4 Competency of the specific skills related to management of challenging behavior

1.2.5 Competency of the behavior management procedures

1.2.6 The organization provides ongoing training opportunities and competencies, at least annually, to maintain staff performance

1.2.6.1 Ongoing training should include knowledge-based trainings, written post-tests to ensure acquisition of knowledge, and – when appropriate, physical demonstration of skills

1.3 Informed consent is obtained from caregivers with decision making authority

1.3.1 The consent process fully describes policies and procedures regarding each procedure and treatment component

1.3.2 The rationale and criteria for the use of each treatment component is fully described

1.3.3 If consent is not given, the organization addresses concerns and collaborate with caregivers to develop alternatives if possible

1.4 Behavioral Interventions are developed and applied in a manner consistent with best practices

1.4.1 Procedures are based on functional behavioral assessment findings

1.4.2 Procedures are minimally restrictive, not harmful or abusive

1.4.3 Treatment procedures are based on established best practices

1.4.4 Intervention plans identify objective and quantifiable targets for treatment and goals, including those that:

1.4.4.1 increase adaptive replacement behaviors and skill building components

1.4.4.2 arrange predictable routines

1.4.4.3 extinguish old patterns of behavior

1.4.5 If behavior management techniques to prevent and interrupt challenging behavior are necessary, they are developed and used in accordance with behavior management policies

1.4.6 If crisis management procedures are necessary, they are developed and used in accordance with crisis management policies (see CM 1 below)

1.5 Behavioral treatment procedures are clearly described and objectively monitored for safety by qualified professional staff

1.5.1 Documentation describing behavioral management techniques in an individual's plan of care include with a sufficient level of detail to ensure it can be applied as intended

1.5.2 Documentation clearly reports any injury to staff or individual

1.5.2.1 Qualified professional staff are be notified of injury

1.5.3 Use of behavior management procedures is recorded and monitored to evaluate efficacy and reduction of use

1.5.3.1 Data collection includes, and is limited to:

Frequency of challenging behavior, frequency of behavior management procedures

2.6. Behavioral management techniques are used within behavioral treatment programs when necessary to prevent or interrupt challenging behavior that poses risks or interferes with functioning. These techniques are always used in conjunction with behavioral treatment.

2.6.1 Behavior management techniques includes a variety of procedures such as response blocking, transport procedures, or protective equipment that does not limit movement

2.6.2 Behavior management procedures should be outlined in an individual's behavior treatment plan

2.6.3 Professional staff qualified by training and experience should develop criteria for when behavioral management techniques should be applied. The least restrictive technique should be applied first

**Crisis Management Policy (CM)**

1. Guiding Principles

Crisis management refers to a particular type of management that is more reactive when challenging behavior has escalated to crisis levels and risks are imminent. Crisis management is warranted or medically necessary given the severity of behavior and immediate risks, after lesser interventions have been tried and failed, or are deemed insufficient. Crisis management procedures are not a replacement for an individualized treatment plan but are used in addition to treatment when the need arises.

2. Policies for the Development, Application, and Monitoring of Crisis Management

To ensure safe and effective management, organizations adhere to the policies outlined for behavioral treatment in addition to specific crisis management policies summarized below. The organization develops policies to ensure that:

2.1 Crisis management procedures are developed by professionals with special expertise on crisis management procedures

2.1.1 Procedures are applied in a manner consistent with applicable state and federal law

2.2 Procedures are utilized in crisis situations for dangerous or harmful behaviors that occur at unpredictable times and place the individual or others at risk for injury

2.3 Crisis management procedures are applied as a safety measure and used according to well-defined, predetermined criteria

2.3.1 Procedures are clearly defined in the individual's plan of care and include criteria for application, criteria for discontinuation of the procedure (e.g., duration of procedure, duration without challenging behavior), and identify prohibited procedures that are potentially harmful (i.e., isolation in unsafe environments, restricting movement for extended periods of time, holding an individual in life-threatening locations, holding an individual in a harmful manner such as when the procedure would restrict breathing and/or blood flow)

2.3.2 Procedures are minimally restrictive, safe, not harmful or abusive

2.4 Crisis management procedures are implemented by staff who have been trained and demonstrate competency in their application, see BT 2.2

2.4.1 The organization ensures that staff have completed competencies on rights of clients or students and the ethical application of crisis management including:

2.4.1.1 Knowledge of the needs of individuals with Autism and intellectual or developmental disabilities

2.4.1.2 Knowledge of when crisis management procedures are not appropriately selected or effective

2.4.1.3 Awareness that these procedures should not deprive the client or student the opportunity to eat, use the bathroom, or be comfortable

2.4.1.4 That only techniques taught within the organization are approved for use

2.4.1.5 Any issues regarding ability to manage challenging behavior using the taught procedures must be discussed with professional staff

2.4.1.6 Modifications to procedures must be approved by qualified professional staff

2.4.2 The organization ensures that staff receive training that includes demonstration of skills at least annually, including:

2.4.2.1 The specific skills related to management of challenging behavior

2.4.2.2 The specific crisis management procedures

2.4.2.3 General implementation safety guidelines

2.4.2.3.1 Behaviors are not blocked in excess; utilize additional staff for safety; do not create a setting that increases the likelihood of the individual displaying challenging behavior; maintain appropriate and professional interactions

2.5 Use of crisis management procedures requires informed consent, see BT 2.3

2.6 Use of crisis management procedures are clearly documented and objectively monitored for safety, see BT 2.5

# Appendix C

## Recommended Trainings for Behavioral Treatment and Crisis Management

### Crisis Management Programs

In this document we provide a model for identifying and describing recommended trainings for agencies providing services in the assessment, treatment, and management of challenging behavior. Each agency should identify and develop the trainings they will need and these should be mindful of the applicable federal, state, and local statutes and regulations that they operate under. There are a number of existing crisis management programs that are available to care providers and families. Organizations with the expertise may also develop their own crisis management program. Crisis management programs consist of training on crisis prevention, physical management techniques, debriefing, documentation, and reporting.

*Crisis prevention training* includes information on the population receiving services, the functions of challenging behavior, identifying precursor behavior and setting events, and empirically validated techniques for preventing, managing, and redirecting challenging behavior to avert crisis episodes. *Physical management training* includes a variety of techniques that may be used to safely redirect or contain challenging behavior. This training includes when each technique(s) should or should not be used and safety considerations for each technique. Training on debriefing, documentation, and reporting may occur during the crisis prevention and/or physical management training or as separate trainings.

Crisis management training should be provided to all staff who work with individuals who present with challenging behavior or a subset of staff may receive this training and function as the "crisis management team". Whichever model is employed, agencies should also include administrators, professional staff, and direct care staff in these trainings and should identify who should receive additional trainings as appropriate (e.g., restraint reduction initiatives, peer review, additional information on reporting, etc.). Many agencies may also invest in further training to enable some employees (i.e., trainers) to train other employees.

### Crisis Management Trainings

1. **Crisis Prevention**
    a. ***Purpose***. The purpose of this training is to provide trainees with the information and skills to prevent and redirect escalated behavioral episodes before such episodes become a "crisis".
    b. ***Content.*** Crisis prevention trainings are most effective when they are directed towards the needs, communication styles, and cultural differences of specific populations and include a functional approach to understanding the causes of challenging behavior. Crisis

prevention trainings focus on how the challenging behavior functions in the environment and how making changes to the environment before, during, and after challenging behavior can minimize challenging behavior and support adaptive behavior that meets the individual's needs.

c. ***Training Format and Competencies.*** Crisis prevention trainings typically consist of a knowledge-based format combined with some role play and feedback. We recommend that crisis prevention trainings have a knowledge-based test (e.g., written or online) and that redirection techniques are trained through role plays and feedback and require completion of a skill-based competency test (i.e., live demonstration of the skills).

d. ***Regulations and Policies.*** Regulations may specify that training on prevention and the specific population served are required.

e. ***Target Audience.*** Direct care staff and clinicians (i.e., professional staff). We highly recommend that a representative(s) from the administrative also be familiar with the training.

2. **Crisis Management (Techniques)**

a. ***Purpose.*** The purpose of training on crisis management techniques is to provide trainees with a set of skills that can safely manage dangerous behavior. Safety is the primary concern of crisis management training and a general rule is that the techniques that are trained should never be more dangerous than the behavior they are used to manage.

b. ***Content.*** Crisis management trainings include training on some or all of the following techniques: (a) physical management interventions including protective positioning, redirection and/or deflection, physical escorts, and physical restraint, (b) exclusion procedures such as time out, (c) use of protective equipment for both direct caregivers and clients, and (d) mechanical restraint or medically prescribed interventions such as the application and use of arm limiters. In addition, these trainings include when and when not to use each technique as well as safety considerations of using each technique. Finally, these trainings typically include information on documentation, reporting, and debriefing, although some or all of these topics may be addressed in more depth in separate trainings (see below).

c. ***Training Format and Competencies.*** The format of this training is one primarily of practice with feedback until competency is demonstrated. Each technique is broken down into component parts and these parts are practiced to fluency. Role plays combining different techniques are used to train fluency and teamwork and test

application of safety guidelines. Each trainee plays the role of the client during each procedure. These trainings require a written test and physical competencies.

a. ***Regulation and Policies.*** Some techniques may be specifically prohibited under any circumstances (e.g., choke holds, half or full-nelsons, etc.). Some techniques may be generally prohibited but allowed under certain conditions. For example, currently in Massachusetts, prone restraint is not permitted with adults with special needs but is permitted with a waiver for students with special needs under 22 years of age. Some techniques may be designated for "emergency use" only, often defined as imminent harm to the individual or others. Regulations may require a minimum amount of training time and a minimum amount of time for annual refreshers. Regulations may require that specific topics are reviewed in the training. Examples of topics include signs of physiological distress, reporting the use of techniques, debriefing procedures, and so on. Regulations may require specific competencies such as written tests and/or physical competencies.

d. ***Target Audience.*** Direct care staff and clinicians (i.e., professional staff). We highly recommend that at least a representative for administration also be familiar with the training.

**3. Documentation**

a. ***Purpose.*** To ensure proper documentation of the use of crisis management techniques for regulatory and organizational purposes.

b. ***Content.*** For direct care staff, the main content of this training is on how to correctly complete all the required documentation for specific procedures. This includes the rationale for documentation and regulatory requirements. Additional content may be provided for individuals responsible for summarizing the documentation and reporting to regulators.

c. ***Training Format and Competences.*** This training is knowledge-based and typically includes practice scenarios for documentation that are reviewed in the training. Competencies may include a written test and/or successful completion of sample scenarios.

d. ***Regulation and Policies.*** Regulations may require specific types of documentation and/or specific forms be used. For example, regulations may require the names of all involved, the time, the location, a description of the episode, who the episode was reported to, what was happening immediately prior to the episode, where it occurred, and so on.

e. ***Target Audience.*** Direct care staff and anyone responsible for overseeing and/or reporting documentation (e.g., professional staff, administrators).

**4. Reporting**

a. ***Purpose.*** The use of crisis management techniques often represents situations in which severe challenging behavior occurred; reporting this behavior and use of crisis management techniques is important to identify any trends or issues and respond accordingly. Thus, organizations have specific reporting guidelines consistent with federal and state regulations.

b. ***Content.*** This training consists of who and when to report an incident to and what information to share. For direct care staff, reporting will typically be to a supervisor or administrator in the organization. Administrators and professional staff may have additional training on reporting to families and/or regulatory bodies.

c. ***Training Format and Content***. This training is suitable for a knowledge-based format and a written competency.

d. ***Regulation and Policies***. Regulations may require reporting of specific crisis management techniques such as restraint. Reporting guidelines may vary considerably depending on many factors, such as the setting (e.g., school, residential setting, hospital setting), time of day or night, specific crisis management technique involved, etc. Regulations cover what must be reported, when it must be reported, and whom it must be reported to.

e. ***Target Audience***. Direct care staff and anyone responsible for reporting.

**5. Debriefing**

a. ***Purpose.*** The purpose of debriefing is to ensure that everyone involved in an episode is physically and emotionally recovered. A second purpose is to analyze a given episode and determine if changes can be made to training, programming, and/or the environment to prevent or better respond to further episodes. An additional purpose to debriefing is to ensure that restrictive procedures are being used only as needed.

b. ***Content.*** This training reviews the general formats and timelines for debriefing as well as any required or recommended elements of debriefing.

c. ***Training Format and Competencies.*** This training is suitable for a knowledge-based format and role play.

d. ***Regulations and Policies***. Regulations may cover when and how debriefing procedures should be conducted as well as criteria for initiating more extensive reviews such as peer review.

e. ***Target Audience***. Direct care will typically be informed of debriefing processes during the crisis management techniques training but may not have a separate training on debriefing; professional staff and/or administrators may have a more extensive training on how and when to conduct debriefings.

**6. Oversight**

a. ***Purpose.*** Crisis management programs require oversight to be implemented ethically and safely. Oversight includes an emphasis on consistent review, high levels of supervision, immediate and complete reporting, comprehensive training, and collaborations and effective communication across departments and agencies. For example, oversight includes access to peer review systems that ensure all restrictive programs are reviewed in terms of efficacy, appropriateness, and safety on a regular basis and emergency cases can be reviewed promptly. Human Rights Committees should review the use of restrictive procedures periodically to ensure that such procedures are in the best interest of the individuals they are used for. Administrators should review data on restrictive procedures regularly to ensure that the use of restrictive procedures meets all of the relevant guidelines. Organizations and/or regulators may require that physicians approve the use of specific procedures for their patients, or at the very least note that the patient has no known underlying medical conditions that preclude the use of any procedures.

b. ***Content.*** For direct care staff, information on oversight systems will typically be included across specific trainings – this information will typically be limited to the existence and purpose of oversight committees and procedures. Members of committees and those responsible for carrying out procedures and policies will receive more specific training on the relevant procedures. For example, clinicians involved in peer review will receive training on what, when, and how to present programs and data to other committee members.

c. ***Training Format and Competencies.*** This training is suitable for a knowledge-based format.

d. ***Regulations and Policies.*** Some oversight committees and procedures may be required by regulations. For example, many states may require that restraints are reviewed by a

peer review committee if they meet specific criteria. Other committees and procedures may not be required by regulations but may still be best practice.

e. ***Target Audience.*** The target audience includes direct care staff, who should be aware of general policies and procedures, as well as clinicians and administrators who participate and/or oversee oversight committees and procedures.

**Crisis Management Program Checklist.** A crisis management program should only be adopted if, at a minimum, it meets the following criteria:

1. The program is informed by and consistent with all federal, state, and local laws as well as applicable regulations. Example of regulations are provided below - it is the responsibility of the provider to know and follow applicable laws and regulations.
    a. Some techniques may be specifically prohibited under any circumstances (e.g., choke holds, half or full-nelsons, etc.).
    b. Some techniques may be generally prohibited but allowed under certain conditions. For example, in Massachusetts, prone restraint is not permitted with adults with special needs, but is permitted with a waiver for students with special needs under 22 years of age.
    c. Some techniques may be designated for "emergency use" only, often defined as imminent harm to the individual or others.
    d. Regulations may require a minimum amount of training time and a minimum amount of time for annual refreshers.
    e. Regulations may require that specific topics are reviewed in the training. Examples of topics include signs of physiological distress, reporting the use of techniques, debriefing procedures, and so on.
    f. Regulations may require specific competencies such as written tests and/or physical competencies.
    g. Regulations may require regular review and/or review contingent upon specific criteria (e.g., more than one physical restraint in a week for the same individual might trigger a review).
2. The procedures employed by the program have been reviewed by the appropriate professionals. This includes regulating agencies, physicians and agency decision-makers (e.g., principals, CEOs, clinicians).

3. The crisis management program must be consistent with best practices (see Note below for currently available crisis management training programs.)
    a. The program must have a clear rationale for the use of the procedures (i.e., safety, doing no harm) that is consistent with the best interest of the client and all relevant regulations
    b. The crisis prevention techniques should be empirically-based

c. The physical management techniques (e.g., escorts, restraints, applying protective equipment to clients, etc.) must be trained to competency using role play and feedback and must be
    i. Prescriptive (what to do, e.g., hold individual's arm above the wrist and below the elbow) and proscriptive (what not to do; e.g., never touch another individual's neck, never place pressure on the chest, etc.)
    ii. Trained with specific guidelines for the use of each procedure including when these procedures are to be used, when they are not be used, guidelines for release, and safety guidelines
    iii. Trained with an emphasis on teamwork and communication
d. A written test on implementation and safety guidelines

4. Documentation of procedures and reporting requirements must meet all relevant regulations and organization standards – this requires training for all staff involved with procedures and additional training for all staff responsible for overseeing the procedures and data (e.g., supervisors, principals)

5. Crisis management programs must include a robust debriefing process to ensure that restrictive techniques are being used only when they are in the best interest of the client, that they are being implemented safely, and that all concerns by the client, staff, and others are heard and addressed
    d. Incorporated into crisis management training
    e. May be additional trainings and requirements for supervisors (e.g., direct care staff need to know how to report a restraint, to check for everyone's safety during and after a restraint, etc.; a supervisor may need to know who and when restraints get reported to outside of the agency, that x number of restraints in a given time period for a given individual trigger a special review process, etc.)
    f. Physical competencies and a written test (CALM-P)
    g. Additional content relevant to population served and/or individual histories (training on population; e.g., additional content on trauma, additional content on safe procedures for individuals who using wheelchairs , etc.)
    h. Often a minimum duration of training (x hours min.; regulatory) and a minimum requirement for refresher trainings (time interval)

6. Training Requirements – approving and monitoring crisis management procedures

a. All relevant legal and regulatory provisions (direct care staff need to be aware of regulations; supervisors need to have additional training for their roles in implementing the regulations (see below for specifics)
b. Reporting requirements (when and to whom procedures must be reported, and in what format) – this training is for direct care staff
c. Review requirements, including how each procedure is reviewed as well as regular and emergency reviews – this training is for supervisors
d. Additional content as appropriate for population served (e.g., DEI training, working with families, secondary trauma, etc.).

7. System Supports [Structural Processes]
    a. Peer Review process
    b. Philosophy of treatment and use of crisis management preventions
        i. Clear guidelines on use of emergency techniques
        ii. Robust debriefing process
        iii. Commitment to using techniques only as needed
    c. System for monitoring and tracking use of intrusive techniques
    d. System for maintaining compliance with all applicable regulation and standards
    e. Informed consent
    f. Proactive promotion of program

Note: Crisis management trainings programs can be developed by service provision agencies but require extensive training and experience to be qualified to do so. There are several established crisis management training programs that offer a variety of training types that focus on crisis prevention and management. Inclusion of links to these programs is not an endorsement of them but is provided as a resource.

Marcus Autism Center:
https://www.marcus.org/autism-training/crisis-prevention-program
https://www.marcus.org/autism-training/crisis-prevention-program/training-prices-and-events

New England Center for Children:
https://www.necc.org/training/calm-p/

Professional Crisis Management Association:
https://crisisintervention.com/
https://www.pcma.cc/training/scheduletraining.aspx

**Training in Skills for Behavioral Assessment and Treatment**

The following trainings are necessary for providing effective behavior intervention. For direct care staff (i.e., Registered Behavioral Technicians; RBTs), the BACB® requires 40 hours of training covering (a) taking and summarizing continuous and discontinuous data, (b) conducting preference assessments, assisting with individualized assessments, and assisting with functional assessments, (c) understanding and implementing basic skill acquisition programs and procedures such as discrete trial training, naturalistic teaching procedures, shaping programs, token economies, and task analyses, (d) understanding and implementing behavior reduction programs including modifying antecedent conditions, delivering differential reinforcement, conducting extinction procedures, and implementing crisis management techniques, (e) documentation and reporting, (f) professional conduct and scope of practice, and (g) the RBT Ethics Code. These trainings map on well to the recommended trainings for direct care staff working with individuals who exhibit challenging behavior. Considerably more training, education, and supervised experience is required for professional staff in order to supervise and train direct care staff, design, implement, and evaluate assessments, skill acquisition programs, and interventions, and so on.

**Data Collection**

Data collection on behavior is an important part of treatment assessments and evaluations and necessary to make informed decisions for clients' treatments. Data can be collected on behavior that direct care staff or supervisors are looking to decrease (e.g., aggression, self-injury, tantrums, etc.) or increase (e.g., functional communication, self-initiation, reading, etc.). Progress can be determined by analyzing collected data, and adjustment to the treatment can be made accordingly.

By defining measurable behavior, confusion and mistakes in data collection can be avoided, and multiple data collectors can record objective, reliable data.

**Data Collection Trainings**

1. **Defining and measuring behavior**
    - **b.** ***Purpose.*** To objectively define the target behavior and effectively measure behavior to inform a treatment.
    - ***c.*** ***Content*** For direct care staff, the main content of this training is on how to correctly measure defined target behavior. This includes the rationale for measuring the target behavior. For supervisors responsible for identifying and operationally defining the target behavior, additional content may be provided on how to operationally define an observable and measurable behavior.
    - **d.** ***Training Format and Competencies.*** This training is lecture-based and typically includes practice scenarios for data collection methods that are reviewed in the training.

Competencies may include a written test and/or successful completion of sample scenarios.

**e.** ***Regulation and Policies.*** Handling personal information.

**f.** ***Target Audience.*** Direct care staff and professional staff.

**2. Data Collection Methods**

**a.** ***Purpose.*** To ensure that trainees understand which measurement method is appropriate for the behavior that is being measured and are competent in utilizing those measurement methods.

b. ***Content.*** This training reviews the different data collection methods, based upon what information is needed for the type of behavior being exhibited and what change is desired (increase, decrease, maintenance). Data collection training may include some or all the following methods: (a) continuous data collection (frequency, rate, duration, latency), (b) discontinuous data collection (partial interval, whole interval, momentary time sampling), (c) antecedent-behavior-consequence data collection, (d) permanent product.

**c.** ***Training Format and Competencies.*** This training is lecture-based and typically includes practice scenarios for data collection methods that are reviewed in the training. Competencies may include a written test and/or successful completion of sample scenarios.

**d.** ***Regulation and Policies.***

**e.** ***Target Audience.*** Direct care staff and professional staff.

**3. Data Reliability**

**a.** ***Purpose.*** To ensure that trainees are competent in collecting valid, reliable, and accurate data on behavior. Reliability of measurement refers to the consistency of measurement, the extent to which repeated measurement of the same event yields the same values. Validity involves the extent to which the data obtained from measurement are directly relevant to the target behavior. Accuracy involves the extent to which the data produced by measuring the event, match the true state of the behavior or event.

**b.** ***Content.*** This training reviews the common threats to validity, reliability, and accuracy and systems of interobserver agreement.

**c.** ***Training Format and Competencies.*** This training is knowledge-based and typically includes practice scenarios for data collection methods that are reviewed in the training.

Competencies may include a written test and/or successful completion of sample scenarios.

**d.** ***Regulation and Policies***

**e.** ***Target Audience.*** Direct care staff and professional staff.

**Understanding and Assessing Challenging Behavior**

The following trainings are designed for direct care staff. Clinicians will receive considerably more training as part of their fieldwork and certification. At a minimum, direct care staff should have a basic understanding of why challenging behavior occurs (i.e., the challenging behavior serves a function for the individual) with many examples relevant to their setting. We strongly recommend a contextual, functional approach to understanding challenging behavior. In addition, factors such as medical conditions should be included to provide a comprehensive understanding of challenging behavior.

**1. Assessing Challenging Behavior – Understanding the Functional Approach**

**a.** ***Purpose.*** To orient direct care staff to a functional, contextual approach to understanding challenging behavior. In this approach, challenging behavior serves a function for the individual and is supported in some way by the interactions of the individual with their environment. Understanding the function of behavior is critical to understanding how to treat challenging behavior.

**b.** ***Content.*** Specific content may vary, but in general content should include (a) general principles of operant behavior such as motivation, reinforcement, extinction, punishment, and generalization; (b) how challenging behavior can be maintained by its consequences; (c) general interventions and procedures that address challenging behavior.

**c.** ***Training Format and Competencies.*** This training is suitable for a knowledge-based format and a written competency.

**d.** ***Regulation and Policies***.

**e.** ***Target Audience.*** Direct care staff.

**2. Conducting Assessments**

**a.** ***Purpose.*** To train direct care staff to implement common types of assessments. For challenging behavior, these assessments may include interviews, direct observation, and/or causal analyses such as functional analyses.

**b.** ***Content.*** Content includes understanding and completing common assessment forms and reading and implementing assessment protocols. Specific protocols will vary depending on the setting, but may include such assessments as the structured clinical interviews, preference

assessments, functional assessment rating scales, descriptive observations, functional analyses, and so on.

c. ***Training Format and Competencies.*** Both knowledge-based and skill-based formats should be used. Knowledge-based formats can train reading forms and protocols, whereas skill-based formats such as BST should be used to train implementation of the assessments.
d. ***Regulation and Policies***.
e. ***Target Audience***. Direct care staff.

3. **Designing and Evaluating Assessments**
    a. ***Purpose.*** To identify appropriate assessments and modify these assessments as needed based upon the individual client and the setting.
    b. ***Content.*** In-depth review of assessments in order to train which assessments are appropriate for different conditions, why and how common assessments may be modified to meet the individual needs of the client, and how the results of the assessments should be evaluated.
    c. ***Training Format and Competencies.*** Knowledge-based format that may incorporate scenarios. Competencies?
    d. ***Regulation and Policies***.
    e. ***Target Audience***. Clinicians and supervisors. Many clinicians will have received this training as part of their credential (e.g., BCBAs will have experience, education, and training in conducting functional analyses).

**Behavioral Interventions**

Various behavioral interventions have been designed and developed for direct care staff and families. Behavioral interventions consist of protocols and programs that are designed to either increase identified target behavior (e.g., communication skills, social skill, self-care, leisure skills, motor skills) or decrease identified target behavior (e.g., self-injurious behavior, aggressive behavior, destructive behavior). These interventions include but are not limited to: antecedent-based interventions; differential reinforcement of alternative, incompatible, or other behavior; discrete trial training, functional communication training, modeling, naturalistic teaching, redirection, prompting, and visual supports. A behavioral intervention should be evidence based, and it should be written to meet the needs of the individual for which it is intended.

1. **Behavioral intervention training**
    a. **Purpose.** To train direct care staff to implement behavioral interventions. Various behavioral interventions have been designed and developed for care providers and families. Behavioral

interventions consist of protocols and programs that are designed to either increase identified target behavior (e.g., communication skills, social skill, self-care, leisure skills, motor skills) or decrease identified target behavior (e.g., self-injurious behavior, aggressive behavior, destructive behavior).

**b. Content.** This training reviews how to use an identified alternative behavior to the target problem behavior, and how to use a behavioral intervention to safely withhold reinforcement for the target problem behavior. These interventions include but are not limited to; antecedent-based interventions, differential reinforcement of alternative, incompatible, or other behavior, discrete trial training, functional communication training, modeling, naturalistic teaching, redirection, prompting, and visual support.

**c. Training format and competencies.** Intervention trainings are primarily knowledge-based and typically includes practice scenarios for data collection methods that are reviewed in the training. Competencies may include a written test and/or successful completion of sample scenarios.

**d. Regulation and Policies.**

**e. Target audience.** Behavioral intervention training can be provided to all staff who work with individuals who would benefit from behavior treatment. Agencies should include professionals in the training, and intervention programs should be overseen by a BCBA®. A behavioral intervention should be evidence based, and it should be written to meet the needs of the individual for which it is intended.

# Appendix D


ModelPolicy_BehTx&
CrisisManagement_7.


ModelPolicy_BehTx&
CrisisManagement_Pc


Sample Knowledge
Competency - Crisis M


Sample Skills
Competency - Crisis M