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A Descriptive Analysis of Restrictive and Intrusive Procedures in Behavior Support Plans

Kelsey Webster

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by

Kelsey E. Webster

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Thesis Committee:

Stephanie Peterson, Ph.D., Chair
Wayne Fuqua, Ph.D.
Jonathan Baker, Ph.D.

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Kelsey E. Webster, M.A.

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Restrictive and intrusive procedures are used in the course of effective treatment to protect the safety of clients and others. Nonetheless, behavior analysts have an ethical obligation to implement the least restrictive procedures possible that are still deemed effective. However, when fading procedures for restrictions and intrusions are not a mandatory component of behavior support plans, these procedures may be in place longer than necessary. Extended utilization of restrictive and intrusive procedures could be viewed as limiting the client's rights, especially if less restrictive procedures would also produce successful outcomes. One reason that these procedures are overused may be that behavior analysts have limited guidance and knowledge in developing efficient fading procedures. Therefore, the purpose of this study is to conduct a descriptive analysis of all behavior support plans with restrictive procedures reviewed by one Behavior Treatment Committee at a Community Mental Health program.

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Introduction

Restrictive procedures are interventions that prevent the engagement of a target behavior of interest. State laws as well as practice specific ethical codes stipulate the use of restrictive procedures but define them slightly differently. For example, in Michigan, the Michigan Department of Health and Human Services (MDHHS) defines restrictive techniques as, procedures that result in the limitation of an individual's rights such as the right to receive and send mail; use the telephone; choice of visitors; entertainment materials, information, news; religion; personal property; money; and freedom of movement (MDHHS, 2012). Conversely, behavior analysts define restrictive procedures as, "types of interventions that physically impede the occurrence of behavior by restricting movement or otherwise preventing completion of the target response" (Fisher, Piazza, & Roane, 2011; p. 301).

Similarly, intrusive techniques, defined by the MDHHS, are "those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of a seriously aggressive, self-injurious, or other behavior that places the individual or others at risk of physical harm" (MDHHS, 2012). Examples of intrusive techniques are mechanical restraints, room searches, use of medications for behavior management purposes, etc. However, according to the behavior analytic definition, many intrusive techniques may function as restrictions by preventing movement and alternative responses (e.g., arm splints and other types of restraints).

Regardless of the specific definition, restrictive and intrusive procedures are commonly used in behavior support plans (BSP) for individuals that engage in challenging behavior in order to protect the safety of themselves and others. Though at times necessary, these procedures can be problematic. Client rights may be compromised when these interventions prevent the opportunity to engage in specific behaviors, therefore preventing the client from gaining skills

that would promote independence. For example, a freedom of movement restriction (e.g., no community access) may be implemented for an individual due to a history of engaging in unsafe behaviors while out in the community. By preventing access to the community, alternative appropriate responses (e.g., how to engage in appropriate behavior while in the community) are not practiced or taught. Consequently, a cycle is created in which the client does not develop the skills necessary to justify the removal of the restriction causing indefinite continuation of the procedures.

In an attempt to remediate the over/prolonged use of restrictive and intrusive procedures, BSPs in the state of Michigan are required by MDHHS to be reviewed by a Behavior Treatment Committee (BTC; MDHHS, 2012). BTCs were formed to help protect the rights of clients by ensuring that only the least restrictive procedures necessary for behavior change and client safety were used. These committees are made up of at least three professionals, including a licensed psychologist, a physician/psychiatrist, and one member of the Office of Recipient Rights. Depending on the committee, they may also include board certified behavior analysts (BCBA), various members of Community Mental Health, and other medical/health professionals. BTCs review restrictive and intrusive strategies included in BSPs and monitor the overall effectiveness of the interventions in producing clinically significant behavior change (MDHHS, 2012). While BTCs are tasked with ensuring there is appropriate rationale for the strategies along with monitoring their use, there is little to no guidance on removing already administered restrictive and intrusive procedures.

Along with state enforced client right protections, behavior analysts also have their own guidelines to remediate prolonged use of restrictive/intrusive procedures. In their seminal article, later adapted into the Behavior Analysis Certification Board (BACB) Professional and Ethical Compliance Code (PECC; 2014) section 4.09, Van Houten et al. (1988) argued that individuals

have the "right to the least restrictive yet effective treatment available" (p. 113). That is, individuals have a right to effective treatment which may include the use of restrictive procedures when required to produce effective behavior change. Van Houten et al. furthered stated that restrictive procedures are only acceptable when there is evidence that they are essential to both maintain the safety of the client or others, and to produce a clinically effective behavior change. While Van Houten et al. and the BACB PECC describe the need to use the least restrictive procedures available, they do not prescribe a method for evaluating appropriateness of restrictions and how to remove them.

Cooper, Heron, and Heward (2007) state that, "withdrawal of a successful intervention should be carried out in a systematic fashion" (p. 648). That is, interventions should not be abruptly removed as this could lead to treatment failures. This is particularly important when considering restrictive/intrusive strategies that prevent the opportunity to successfully engage in or learn alternative responses. Thus, treatment success during abrupt removal of these strategies is uncertain and should therefore be systematically faded as to maintain effectiveness and safety. For example, a child that engages in severe head banging when his mother is not able to provide continuous attention may require the use of a helmet to maintain safety. When treatment data suggest that an alternative skill has been developed by the child, systematically fading the use of the helmet would be recommended as opposed to removing the helmet without any transition plan. Otherwise, the child's safety may be at risk.

Though behavior analysts are ethically required to include the least restrictive yet effective procedures in their BSPs, it appears that prolonged use of restrictions and intrusive strategies may be common. Many factors likely contribute to this problem including the lack of an effective and efficient alternative behavior and negative reinforcement on the part of those implementing BSPs by preventing the client from having opportunities to engage in problem

behaviors. In this case, avoidance of the challenging behaviors may be maintaining the prolonged implementation of these procedures. However, context specific variables related to the overuse of the procedures for individuals would be superseded if clear guidelines existed. That is, while negative reinforcement may make therapists more reluctant to remove restrictive/intrusive procedures in some situations, clear guidelines holding the therapist accountable would likely create a stronger negative reinforcement contingency.

Although there is some research on the fading of mechanical restraints (Fisher, Piazza, Bowman, Hanley & Adelinis, 1997; Luiselli, 1991), currently, there is limited guidance at the state level in Michigan regarding the development of restrictive/intrusive removal procedures. While the state requires the inclusion of information like expiration dates and the circumstances under which the justification of the procedure ceases to exist for certain restrictions, a truly systematic method for fading the procedures is not outlined. Additionally, behavior analysts may not have the guidance nor the experience to develop a systematic method of fading out the restrictions and intrusive strategies independently. With no state requirements to fade these procedures and without the guidance and expertise to develop them independently, it is likely that they may be implemented longer than necessary.

It is unclear how prevalent prolonged use of restrictive/intrusive procedures is and what plan writers are doing to remediate it. Because there are no required criteria for fading these procedures, utility and age of restrictive and intrusive procedures are not being evaluated by review committees like BTCs. Therefore, the purpose of this study was to conduct a descriptive analysis of all BSPs with restrictive/intrusive procedures reviewed by one BTC at a Community Mental Health program to determine current procedure practices.

Method

Database and Setting

This study was conducted using a data base of 51 BSPs submitted to a local BTC for review. These plans were already written by various practitioners contracted with Community Mental Health to provide services for children and/or adults diagnosed with developmental disabilities and/or mental illnesses that engage in challenging behaviors. The plans were reviewed, approved, and monitored by the BTC for restrictive/intrusive procedures.

All analyses were conducted at Western Michigan University. BSPs and related information reviewed were viewed on Streamline, an online record system utilized by Community Mental Health and the BTC for storing client BSPs and other client related information.

Materials

Materials used for this study included documents within Streamline including client BSPs, target behavior data, history and health records, etc. Other materials used were a laptop computer, a password protected/encrypted flash drive, and Microsoft Excel®.

Protection of Data: Confidentiality and Privacy

The data used for this study were collected as part of a service contract between Psychological Assessment and Treatment Services and the Community Mental Health BTC. While the data were analyzed at the individual level for the service project, this project only reports data in aggregate form, so no individual recruitment occurred. This study was approved by the Human Subject Institutional Review Board under the exempt category (Appendix A). All spreadsheets used to store coded data were password protected and stored on an encrypted password protected flash drive.

Inclusionary and Exclusionary Criteria

Inclusionary criteria for the BSPs used in this study were, (a) the BSPs were monitored by the BTC and (b) the BSPs included at least one restrictive and/or intrusive procedure. Exclusionary criteria for the BSPs reviewed in this study were (a) any affiliation with Psychological Assessment and Treatment Services (to reduce bias as the investigators worked for this organization) and (b) the only restrictive/intrusive strategy included in the plan was related to medication use for behavioral purposes. Following the implementation of these criteria, a total of 97 BSPs reviewed by the BTC were identified. Of these 97 plans, a random sample of 51 BSPs were reviewed in this study.

Data Analysis

A descriptive analysis of the relevant components of 51 BSPs was conducted. There were no independent variables or manipulations in this study. Data from these plans were inputted and analyzed using Microsoft Excel®.

Dependent Variables

Forty-five dependent variables related to the restrictive and intrusive procedures in BSPs were evaluated in this study. These components were derived from the behavior support plan requirements specified by MDHHS (2012), the literature on the fading of mechanical restraints (Fisher, Piazza, Bowman, Hanley & Adelinis, 1997; Luiselli, 1991), and the general interest of the primary investigators. See dependent variables displayed in Table 1 below. Components categorized under "R/I" included those regarding general information about the restrictions/intrusions. Components denoted by "R" referred to those providing rationale for the procedures and "FP" components were those concerning fading plans. Each of these components (except for IC-5) were evaluated for both restrictive and intrusive procedures.

Table 1

Dependent Variables

Dependent Variables	
R/IC-1	Total number of restrictive/intrusive strategies.
R/IC-2	Most common restrictive/intrusive procedure.
R/IC-3	Categorization of restrictive/intrusive strategies.
R/IC-4	Total number of restrictive/intrusive procedures that included a start date.
IC-5	Number of intrusive strategies that would be classified as a restriction based on the behavior analytic definition (intrusive procedures only).
R-1	Number of restrictive/intrusive strategies that had specified ANY rationale for that procedure.
R-2	Number of restrictive/intrusive strategies that had TARGET behaviors providing rationale for that procedure.
R-3	Number of assessments that discussed the behaviors providing the rationale for the restrictive/intrusive strategy.
R-4	Number of strategies that had specific goals for the related behaviors.
R-5	Number of restrictive/intrusive strategies that had data on the related behaviors.
R-6	Current average of combined relevant target behaviors (up to 6 months).
R-7	Number of restrictive/intrusive strategies that had -0- instances of behavior (up to 6 months).
R-8	Number of restrictive/intrusive strategies with specific behavioral goals and data that indicate the goals are being met.
R-9	Number of restrictive/intrusive strategies that prevented alternative behaviors.
R-10	Number of restrictive/intrusive strategies that included proactive/reactive strategies used to target adaptive replacement behaviors.
FP-1	Number of BSPs that had a fading plan for a restrictive/intrusive strategy.
FP-2	Number of fading plans with criteria.
FP-3	Of BSPs with fading plans, the percentage of restrictive/intrusive strategies that were included in the fading plans.
FP-4	Number of fading plans with a behavior requirement.
FP-5	Of the fading plans with a behavior requirement, the number that had a behavior requirement for each of the behaviors providing rationale for the restrictive/intrusive strategies.
FP-6	Of the fading plans with a behavior requirement, number that included a requirement for unrelated behaviors.
FP-7	Of the fading plans with a requirement for unrelated behaviors, number that the unrelated behaviors were appropriate.
FP-8	Number of fading plans with a duration/opportunity-based requirement.

Data Collection Methods

Data were collected and coded through a thorough review of each of the above components in every BSP included in the study. Operational definitions were developed for necessary components to aid in accurate data collection (Appendix B). The first review was conducted with two researchers collecting consensus data. This consisted of both researchers reviewing each BSP and discussing each component until agreement was found. Data were collected and inputted into a Microsoft Excel® spreadsheet. Data were aggregated for each component across participants.

Following the consensus data collection, a secondary scorer collected independent data for 30% of the behavior support plans. This was collected using the same data sheet and operational definitions used in the original data collection procedures. Before the secondary scorer collected the independent data, the primary researcher trained the research assistant in the data collection procedures. Point-by-point interobserver agreement (IOA) was then calculated for all the plans reviewed by the secondary scorer. BSPs were randomly assigned for IOA using a random number generator. Agreement occurred when the consensus data corresponded with the secondary scorer's data for the relevant component of the BSP. Disagreement occurred when consensus and secondary scorer's data did not correspond (i.e., the secondary scorer's data did not have point-to-point correspondence to the consensus data) for the relevant component. IOA was calculated by dividing the number of agreements by the total number of agreements and disagreements for each component of the BSP, multiplied by 100. Overall IOA for the study, conducted on 15 BSPs, was 84%, ranging from 67% to 100%. After IOA was calculated, disagreements were investigated and reviewed until agreement was found which were then included in the final data set.

Results

The results of this study are separated by restrictive and intrusive procedures as defined by the MDHHS. That is, restrictive procedures are defined as procedures that result in the limitation of an individual's rights while intrusive procedures are "those techniques that encroach upon the bodily integrity or the personal space of the individual" (MDHHS, 2012). For each procedure, the components are presented in three sections (i.e., restrictive/intrusive components, rationale, and fading plan). Each section discusses the results for the corresponding components and if necessary, may be accompanied by the aid of a table. All documented information was strictly based on the material documented and described by the author written in the BSP.

Restrictive Procedures

Restrictive Components. This section reviews those components, labeled RC 1-4 in Table 1, providing general information about the restrictions reviewed in this study. Of the 51 BSPs reviewed, a total of 85 restrictions were identified and evaluated (RC-1). These restrictions were separated into four categories (i.e., supervision, stimuli, communication, and secured living). Supervision restrictions were operationally defined as restrictions that require staff to monitor the client for any duration of time (e.g., freedom of movement, door/window alarms, one-to-one staffing, etc.). Supervision restrictions accounted for 49.4% (i.e., 42) of the restrictions evaluated (RC-3). Within the supervision category, freedom of movement restrictions were the most common form of all restrictions, accounting for 45.9% (i.e., 39) of the strategies overall (RC-2).

Stimuli restrictions were defined as restrictions that prevent the client from accessing personal belongings or other tangible items (e.g., locked refrigerator, cabinets, clothes, etc.). These restrictions accounted for 48.2% (i.e., 41) of the total restrictions (RC-3). Communication restrictions were restrictions that prevent a client from engaging in any mode of communication.

One restriction (i.e., 1.2% of the restrictions) met this criterion and consisted of not honoring a specific mode of communication and redirecting to another (RC-3). Lastly, secured living restrictions were those that required a client to live in an environment where they were prevented from leaving as a through the use of a locked or gated facility. One of 85 restrictions (1.2%) met this criterion (RC-3). Lastly, one of these identified restrictions indicated a start date (1.2%; RC-4).

Rationale. This section presents components R 1-10 in Table 1. Each component listed is specific to or related to the rationale the author provided for the implementation of a restrictive procedure. These results are listed in Table 2. Although most of the authors indicated the rationale for the restriction, few authors addressed those behaviors providing rationale within their assessments or did not discuss assessments conducted at all. Further, very few authors established specific goals for reduction of the behaviors providing rationale for the restriction (i.e., 3). As a result, limited data provided (i.e., 2) were able to be used to identify if client goals were being met (i.e., 3). Of note however, of the restrictions providing data (i.e., 43), 39.5% of them had zero instances of behavior within the last six months. Lastly, half of the restrictions put in place prevented the client from engaging in alternative behaviors. For example, staff has the client's lighter at all times, so client is not able to display appropriate behaviors while having access to the lighter (i.e., lighter restriction). Further, only 10.6% of the restrictions in place targeted teaching adaptive replacement behaviors.

Fading Plan. Results described within this section report fading plan components, labeled FP 1-8 in Table 1. Table 3 presents the aggregate data for each of the eight components. Five fading plans, defined as any systematic plan to terminate or reduce the use of a restriction or intrusive procedure, were identified that addressed a restrictive procedure. Each fading plan listed criteria. Specifically, all five listed a behavior requirement and three of five listed a

duration/opportunity-based requirement. However, only 40% of the fading plans included a behavior requirement for each behavior providing rationale for the restrictive procedure. Forty percent of the fading plans also included requirements for unrelated behaviors, although each were appropriate by aiding in decreasing the behaviors providing rationale for the strategy and/or would help maintain appropriate behaviors. Further, the BSPs that had fading plans included 11 total restrictions that were implemented. These fading plans only addressed 45% (i.e., 5) of the restrictions/intrusions in the plan rather than planning for the removal of all the restrictions/intrusions in place (i.e., FP-3).

Table 2

Rationale Components for Restrictive Procedures

Component		Quantity	Percentage
R-1	Number of restrictive strategies that had specified ANY rationale for that procedure.	66/85	77.6%
R-2	Number of restrictions that had TARGET behaviors providing rationale for the restriction.	59/85	69.4%
R-3	Number of assessments that discuss the behaviors providing the rationale for the restriction.	7/85	8.2%
R-4	Number of restrictions that have specific goals for the related behaviors.	3/85	3.5%
R-5	Number of restrictions that have data on the related behaviors.	43/85	50.6%
R-6	Current average of combined relevant target behaviors (up to 6 months).	4.5 per month	N/A
R-7	Number of restrictions that have -0- instances of behavior (up to 6 months).	17/43	39.5%
R-8	Number of restrictions with specific behavioral goals with data that indicate the goals are being met.	2/3	66.7%
R-9	Number of restrictions that prevent alternative behaviors.	42/85	49.4%
R-10	Number of restrictions that include proactive/reactive strategies used to target adaptive replacement behaviors.	9/85	10.6%

Intrusive Strategies

Intrusive Components. This section reviews components labeled IC 1-5 in Table 1, providing general information about the intrusive strategies reviewed in this study. Of the 51 BSPs reviewed, a total of 26 intrusive procedures were evaluated (IC-1), one indicating a start

date (3.8%; IC-4). These intrusive procedures were separated into four categories (i.e., medication, mechanical, privacy, and bodily integrity). Intrusive procedures due to medication included those medications that have been prescribed for behavior altering purposes. These intrusive procedures accounted for 19.2% (i.e., 5) of the intrusive procedures evaluated (IC-3). Because medications are medical in nature and behavior analysts do not have much influence on them, the researchers took note that these strategies were included in the BSP but did not evaluate the strategies further. That is, the researchers did not collect data on components R 1-10 or FP 1-8 for these strategies.

Table 3

Fading Plan Components for Restrictive Procedures

Component		Quantity	Percentage
FP-1	Number of BSPs that had a fading plan for a restrictive strategy.	5	N/A
FP-2	Number of fading plans with criteria.	5/5	100%
FP-3	Of BSPs with fading plans, the percentage of restrictions that were included in the fading plans.	5/11	45%
FP-4	Number of fading plans with a behavior requirement.	5/5	100%
FP-5	Of the fading plans with a behavior requirement, number that had a behavior requirement for each of the behaviors providing rationale for the restriction.	2/5	40%
FP-6	Of the fading plans with a behavior requirement, number that also included a requirement for unrelated behaviors.	2/5	40%
FP-7	Of the fading plans with a requirement for unrelated behaviors, number of the unrelated behaviors were appropriate.	2/5	40%
FP-8	Number of fading plans with a duration/opportunity-based requirement.	3/5	60%

Mechanical intrusive strategies were strategies including the use of a mechanical device to restrict an individual's movement (e.g., arm splints, H-straps, helmets, etc.). These strategies accounted for 15.4% (i.e., 4) of the total intrusive strategies (IC-3). Intrusive procedures under the "privacy" categorization were those strategies that encroached on an individual's personal space (does not include body) or personal items (MDHHS, 2012). For example, room searches,

sound monitor, supervision, etc. This accounted for 53.8% (i.e., 14) of the intrusive strategies reviewed (IC-3). Specifically, room searches were the most common of all intrusive strategies, accounting for 38.5% (i.e., 10) of the strategies overall (IC-2). Lastly, intrusive procedures that were categorized as "bodily integrity" were those that encroached on a client's physical body but did not include the use of mechanical restraints (e.g., body search, physical management, etc.; MDHHS, 2012). This accounted for 11.5% (i.e., 3) of the intrusive procedures. Of all the intrusive strategies implemented 19.2% (i.e., 5) would have been categorized as a restriction according to the behavior analytic definition. These mostly included the use of mechanical restraints.

Rationale. This section reviews components R 1-10 in Table 1. Each component listed is specific to or related to the rationale the author provided for the implementation of an intrusive strategy. These results are listed in Table 4. Similar to the restrictive strategies, most of the authors indicated the rationale for the intrusive strategy, however, a small quantity of authors addressed those behaviors providing rationale within their assessments or did not discuss assessments conducted at all. In addition to few assessments of these behaviors, very few authors established specific goals for reduction of these behaviors. Also, of the 13 intrusive strategies that included data, 69.2% had indicated that zero instances of behavior had occurred within the last six months. Lastly, one third of the procedures put in place prevented the client from engaging in alternative behaviors (e.g., client is put in an arm splint and as a result cannot bend their arms and practice engaging in appropriate behaviors without the use of the arm splint [mechanical restraint]), but 11.5% of the BSPs with intrusive strategies in place targeted teaching adaptive replacement behaviors.

Table 4

Rationale Components for Intrusive Procedures

Component		Quantity	Percentage
R-1	Number of intrusive strategies that had specified ANY rationale for that procedure.	16/26	61.5%
R-2	Number of intrusive strategies that had TARGET behaviors providing rationale for the strategy.	14/26	53.8%
R-3	Number of assessments that discuss the behaviors providing the rationale for the intrusive strategy.	3/26	11.5%
R-4	Number of intrusive strategies that have specific goals for the related behaviors.	2/26	8%
R-5	Number of intrusive strategies that have data on the related behaviors.	13/26	50%
R-6	Current average of combined relevant target behaviors (up to 6 months).	0.9 per month	N/A
R-7	Number of intrusive strategies that have -0- instances of behavior (up to 6 months).	9/13	69.2%
R-8	Number of intrusive strategies with specific behavioral goals with data that indicate the goals are being met.	1/2	50%
R-9	Number of intrusive strategies that prevent alternative behaviors.	9/26	34.6%
R-10	Number of intrusive strategies that include proactive/reactive strategies used to target adaptive replacement behaviors.	3/26	11.5%

Fading Plan. Results discussed within this section report fading plan components for intrusive procedures, labeled FP 1-8 in Table 1. Table 5 presents the aggregate data for each of the eight components. Of all BSPs reviewed, 3.8% (i.e., 1) included a fading plan for an intrusive strategy. The fading plan listed criteria for both behavior and duration.

Discussion

Restrictive and intrusive procedures are commonly included in BSPs to protect the safety of clients and others. Although these procedures help ensure safety, “they are generally viewed as highly intrusive, undesirable, and generally inadequate approaches to intervention that should only be used in emergency situations” (Fisher, Piazza, & Roane, 2014, pg. 301). While restrictive procedures should be used sparingly, there is currently a lack of resources and research evaluating the use of these strategies. Therefore, the purpose of this study was to

conduct a descriptive analysis of all BSPs with restrictive and intrusive procedures reviewed by one BTC at a Community Mental Health program to determine current procedure practices. It is hoped that the information found in this study will bring awareness to the problem of overuse and will provide a basis for future researchers interested in this topic.

Table 5

Fading Plan Components for Intrusive Procedures

Component		Quantity	Percentage
FP-1	Number of BSPs that had a fading plan for an intrusive strategy.	1	N/A
FP-2	Number of fading plans with criteria.	1/1	100%
FP-3	Of BSPs with fading plans, the percentage of intrusive strategies that were included in the fading plans.	1/1	100%
FP-4	Number of fading plans with a behavior requirement.	1/1	100%
FP-5	Of the fading plans with a behavior requirement, number that had a behavior requirement for each of the behaviors providing rationale for the intrusive strategy.	1/1	100%
FP-6	Of the fading plans with a behavior requirement, number that also included a requirement for unrelated behaviors.	0/1	0%
FP-7	Of the fading plans with a requirement for unrelated behaviors, number that the unrelated behaviors were appropriate.	0/1	0%
FP-8	Number of fading plans with a duration/opportunity-based requirement.	1/1	100%

Throughout the course of this study, multiple deficiencies in the use of restrictive and intrusive procedures were identified. The core deficiencies identified in this study were related to the prolonged use of restrictive and intrusive procedures, the rationale provided for the use of the procedures, and the fading plan for the procedures. Regarding the prolonged use of restrictive and intrusive procedures, authors of BSPs did not provide the necessary information to truly evaluate the problem. Meaning, the primary concern related to prolonged use currently is a lack of information related to tracking the use of these procedures. Of the BSPs reviewed, only one restrictive and intrusive strategy included the date of onset and could, therefore, be evaluated for prolonged use. By not tracking the start of these procedures, it is more likely that prolonged use will go unnoticed further limiting client's rights, independence, and quality of life.

Many components reviewed in this study raised suspicions that overuse of restrictions and intrusions may be present. Various components related to the rationale provided for restrictive and intrusive procedures (i.e., components R 1-10) were lacking sufficient information to adequately justify the implementation of the procedures. Specifically, deficits in the rationale for many restrictive and intrusive procedures include: no behaviors providing rationale for the procedure; behaviors providing rationale were not target behaviors in the BSP; target behaviors had not occurred for the last six months; data were not provided at all; no goals were specified; no assessments were conducted on the behavior of interest; and no adaptive behaviors were targeted as replacements.

The first major deficit identified was that many BSP authors did not provide any behaviors providing rationale for the restriction and/or intrusion. Because the use of restrictive and intrusive procedures can limit a client's rights and prevent them from being independent, these procedures should only be used when there is a safety concern. Not providing a rationale is particularly problematic because there are then restrictive/intrusive procedures in place without a perceived intention or safety concern. Additionally, of the behaviors that were identified, many were not targeted behaviors in the BSP, both of which lead to the absence of the implementation of data collection methods. Without collecting data on these behaviors, it is impossible to accurately determine how often these behaviors are occurring. Deprived of this information, authors cannot make data-based decisions to evaluate the effectiveness of the treatment which may extend implementation time.

Another problem identified in the review was the lack of specific goals for each of those behaviors providing rationale for the restrictive/intrusive procedure. If there are no set performance criteria that would indicate the procedure is longer necessary, it is unclear how well the client must perform in order to be successful without the support of these procedures. For

instance, 17 restrictions and 9 intrusions provided data that indicated that target behaviors had not occurred within the last six months. This may indicate a successful treatment and that the procedure is no longer required. However, these data may also be a result of a restriction or intrusive procedure preventing the client from engaging in that behavior. That is, the client does not have the opportunity to respond (e.g., arm splint, locked cabinets, lighter restriction, etc.). When target behaviors are not occurring, specific goals will likely prompt the author of the BSP to assess if the restrictive/intrusive procedures are still required after the goal has been met. Contrarily, if there are no specific goals there is no prompt to remove these procedures when they are no longer necessary.

Further, the BACB Professional and Ethical Compliance Code (2014) section 4.03 states, "Behavior analysts must tailor behavior-change programs to the unique behaviors, environmental variables, assessment results, and goals of each client" (pg. 12). Without assessing the behavior, it becomes less likely that the treatment developed will be effective in decreasing the problem behavior. Authors may then resort to default technologies which may be more restrictive. With the lack of assessments and use of default technologies, it is unlikely that the author of the plan can identify and target teaching adaptive replacement behaviors. In this case, the client would never acquire the skills needed to be successful without the support of the restrictive/intrusive procedures.

In summary, there are many limitations within the rationale provided for restrictive/intrusive procedures including multiple deficiencies with the behaviors providing rationale, data and goals on those behaviors, assessments conducted, and adaptive replacement behaviors targeted. One solution to decrease the potential for overuse of restrictions and intrusions are to include a systematic process to reduce and/or remove the procedures, unfortunately, only six of 51 BSPs included fading procedures (see Table 6 for examples).

Although the included fading plans were a good start, deficiencies within the fading plans were identified. Specifically, the few plans included; lack of addressing all restrictive/intrusive procedures implemented; lack of including duration/opportunity criteria; lack of including all behaviors providing rationale for the procedure; and making non-related behaviors contingent on reduction/removal.

Of the six fading plans, not all of the restrictive/intrusive strategies implemented in the BSP were targeted for reduction/removal. This may be a result of that strategy being deemed inappropriate for removal (e.g., medical restrictions recommended by a doctor, freedom of movement restriction for an individual who in the past has molested children, etc.). This may also be based on the author's lack of guidance on how to fade the type of procedure or fear of removal by the treatment team. However, the authors of the BSPs reviewed did not make this distinction clear. Regardless, the absence of a plan to reduce/remove each restrictive/intrusive procedure in the BSP will result in lingered use of the procedure.

The criteria (i.e., behavior and duration/opportunity) for reduction/removal provided for fading plans were also problematic. Each of the fading plans included behavior criteria but not all included criteria for each behavior providing rationale for the procedure. For example, a freedom of movement restriction was put in place with the rationale that the client historically engaged in elopement and physical aggression while out in the community. The authors may have included a criterion for elopement but did not include a criterion for physical aggression in the fading plan. This may result in removal of the strategy which allows the client to become more independent, but it may also produce a continued risk of physical aggression and harm to the client and others.

Authors also made non-related behaviors contingent on restriction/intrusion removal. In some cases, it may be advantageous to require the client to engage in additional behaviors like

attending therapy sessions, requiring attendance of psychiatric appointments, etc. (see example five in Table 6 below) if it has proven to be effective in the past and there is rationale that the therapy will aid in the maintenance of success overtime. However, there may also be instances when this would be inappropriate. For example, in the freedom of movement example provided above, the author may also develop a behavior criterion for repeated requests. In this case, repeated requests are not providing rationale for the freedom of movement restriction, so it would be inappropriate to require it for the reduction/removal of the restriction. In this example, the author is requiring a higher standard of performance unrelated to the rationale for the initial implementation of the procedure. This additional requirement may be unattainable and prevent the client from being successful, leading to prolonged use of the procedure.

Another problem with the criteria included was the few fading plans that provided duration or opportunity-based criteria (see example 3 and 4 in Table 6 below). Depending on the frequency and severity of the behavior, the client may need to meet the behavior requirement for shorter or longer periods of time (e.g., six months to a year or longer) to engaged in appropriate behaviors in order to demonstrate success without the support of the restrictive/intrusive procedures. Similarly, the client may need few or many opportunities (e.g., two to five or more outings) to demonstrate success without the support of the restrictive/intrusive procedures. Without these criteria, it is unclear how long or how many opportunities the client must successfully complete before the procedures can be reduced/removed. Consequently, restrictions/intrusions may be implemented for long periods of time even if they continue to meet the behavior requirement (e.g., behaviors that have not occurred at all within the last six months).

In summary, there are many deficiencies within the few fading plans reviewed that included, not addressing each restriction/intrusion in the BSP, and various issues with the criteria developed. In addition to these limitations, deficiencies within the rationale exasperated the

problem. Although the fading plans reviewed in this study were created with good intentions, there is much room for improvement.

Table 6

Summary of Fading Plans Reviewed

Type of Fading Procedure	Description
1. Contingent Restrictive and/or Intrusive Procedure	Fading from non-contingent to contingent restraint.
2. BTC Review	If after the client does not engage in the behaviors providing rationale for the restriction for six consecutive months, the treatment team with consult with the BTC for a potential reduction/removal in the procedure. More than one fading plan reviewed was similar to this example.
3. Stimuli Example	If the client asks to have access to their personal items, if approved by the treatment team, they may have access. If the client refrains from engaging in the target behavior they may retain access to personal items.
4. Freedom of Movement Example	After client completes a safety plan (what the safety plan entails is unknown) and complete a community safety screen, the client may begin by having five minutes of community access. If situations arise that could cause harm, community access will be suspended.
5. Level System	Level 1: No independent walks or community access. Must refrain from target behaviors for one week to meet level 2 criteria. Must also attend all psychiatric and medical appointments to be eligible for level 2 and 3. Level 2: Can take up to an hour walk per shift. Must sign in and out and must be on time. Must also refrain from problem behaviors and attend appointments. If successful for 30 consecutive days, client will meet level 3 criteria. If not, client goes back to level 1. Level 3: Client can take a two hour walk per shift. Must sign in and out and must be on time. Must refrain from target behaviors for one week to meet level 2 criteria. Must also attend all psychiatric and medical appointments. If successful for 60 consecutive days, the treatment team will review with the BTC a further reduction in restrictions.

Fading Plan Development Process

Prior to this project, the primary investigator and colleagues developed a process for systematically writing effective and efficient fading procedures for each restrictive and intrusive procedure included in their BSPs (Table 7). The initial process was derived from the literature on the fading of mechanical restraints (Fisher, Piazza, Bowman, Hanley & Adelinis, 1997; Luiselli,

1991) and collaborating with the treatment team to develop a fading process for one particular client. That initial process has since been adapted overtime. The goal of this process was to provide a systematic method for removing restrictive and intrusive procedures which at times is challenging due to variety. This process is not a validated tool, but rather a resource that authors of BSPs can use to help organize their ideas surrounding their removal of restrictions/intrusions.

With the aid of this process, the primary investigator and colleagues have been able to identify many ways restrictive and intrusive procedures may be faded out. For example, physical restraints may be faded out by requiring the client to wear them less and less overtime, by making them more flexible overtime (e.g., increasing flexibility of arm splints), or by removing portions of the restraints at a time (e.g., removing the face mask of a helmet). Similarly, a cigarette restriction may be faded out by providing access to more and more cigarettes at a time (e.g., client is provided one cigarette at a time, then two at a time, etc.) or by allowing the client to hold onto their cigarettes for longer durations of time (e.g., first for an hour, then two, etc.). Supervision or freedom of movement restrictions may be faded by slowly allowing longer durations of independent community access, or small approximations can be made like going from two-on-one staff supervision, to one-on-one staff supervision, to walks while the staff is directly behind the client, then 20 feet behind the client, etc. Further, room searches may be reduced by slowly fading out the number of room searches conducted over time or by reducing the duration of which room searches are conducted. Regardless, these fading plans should be individualized for your client.

To develop these types of fading processes, multiple steps must be followed which are included in the following process. First, it is important to include the onset date in the BSP so the treatment team and review committees like BTCs are aware of how long restrictive/intrusive procedures have been implemented. It is also important to identify which procedures are

appropriate for reduction/removal. Adaptive behaviors should also be targeted as replacement behaviors. Finally, a meeting with the treatment team should be set to discuss the terminal goal, intermediate steps, mastery criteria, behavior and duration/opportunity-based criteria. These steps are discussed further in Table 7. Further, this process was used to develop examples of two fading plans presented in Table 8 and 9 and are representative of the fading plans developed by the primary researcher and colleagues (Appendix C). Table 8 represents an example of a restriction that is faded out by meeting a single criterion. Table 9 represents an example of a restriction that is faded out systematically by meeting multiple criteria until the restriction is terminated completely.

Conclusion

Many deficits regarding the rationale and fading of restrictive and intrusive procedures were identified in this study. These deficits have serious ramifications, and all contribute to the prolonged use of the procedures. One limitation of this study was the researcher's inability to access the exact age of the procedures by assessing revised plans which may have shown less restrictive procedures overtime. To remedy this problem, BSP authors should include the onset date of the restriction/intrusion in each modified rendition of the BSP. Including the onset date will help hold therapists accountable and prevent the use of prolonged restrictions and intrusive strategies.

Many authors did not provide adequate rationale for the restrictions/intrusions implemented in the BSP. Within this lack of rationale, the absence of assessments may influence many other components including the lack of identifying the target behaviors of interest, collecting data, developing goals, assessing and teaching adaptive replacement behaviors, and most importantly developing an effective treatment. Further, without conducting assessments, it may be impossible to determine if the least restrictive most effective treatments are being

Table 7

Process for Developing Fading Plans for Restrictive/Intrusive Procedures

Fading Plan Development Process	
Steps	Explanation
Step One: Identify possible restrictive/intrusive procedures for reduction/removal.	Determine the appropriateness of the procedure.
Step Two: Identify the behaviors providing rationale for the restriction.	Identify ONLY those behaviors that resulted in the implementation of the procedure.
Step Three: Identify appropriate adaptive behaviors to be taught and a method to teach and reinforce those behaviors.	Identify replacement behaviors for the behaviors providing rationale for the procedure (should address the same function).
Step Four: Establish Fading Plan a. Identify terminal goal.	Identify a goal the would indicate the client would be successful without the implementation of the procedure.
b. Create intermediate steps, consisting of faded approximations of each restrictive/intrusive procedure.	Break down the procedure into smaller approximations to ensure the client remains successful with less and less support from the procedure.
c. Establish mastery criteria for each phase of the removal.	Identify overall criteria that need to be met to move onto the next step in the fading process (i.e., behavior and duration/opportunity-based criteria).
i. Identify behaviors that indicate the individual is not performing successfully.	Identify the behaviors that provide rationale for the procedure.
ii. Determine when to move on to the next step.	Quantify the behavior requirement and duration/opportunity-based criteria that need to be met.
iii. Determine what to do if criteria are not met.	Determine criteria for when to troubleshoot if the criteria in the previous step are not met (e.g., this could mean readjusting criteria, conducting further assessments of the target behavior, and/or modifying the treatment, etc.).

implemented. Additionally, this rationale was typically dispersed throughout the BSPs which resulted in the difficultly to locate the components. As a result of this disorganization, it is recommended that authors utilize the template created by the Department of Psychology at Western Michigan University (2016). This template can be used to guide authors of BSPs to

include all the essential information and allow for ease of reading for the BTC, treatment team, and staff who have to implement it.

In addition to the deficits of the rationale, there were also many related to the use of fading plans. Although one way to stop prolonged use of restrictions/intrusions is the inclusion of fading plans, few authors included a systematic process to reduce or remove them when they are no longer vital for client success. On top of not including fading plans in their BSPs, it appears authors also do not possess the prerequisite information and skills to do so as indicated by the lack of rationale provided for the procedures. To reduce the likelihood of these deficits, it is recommended that authors of BSPs including restrictions/intrusions utilize systems like the proposed fading plan development process described in Table 7 which may prompt them to include this information.

As previously indicated, the authors of these BSPs may not have the prerequisites to develop rationale That is, because some authors of plans have not provided rationale for the procedures implemented, assessed the behaviors providing rationale, developed goals for those behaviors, targeted adaptive replacement behaviors, etc., it is likely that developing a fading process may be particularly challenging. In these situations, it is important to evaluate whether the authors have been taught the skills on how to complete these tasks. That is, the lack of meeting the requirements may be due to a skill deficit. However, the lack of completing these tasks may also be caused from a lack of resources. For example, a large case load or the lack of access to various materials may prevent an individual from having the time to complete the task or the materials they need (e.g., assessment or materials needed to teach adaptive replacement behaviors). Lastly, authors of these plans may not be completing these tasks due to a skill deficit or a lack of resources, but due to a motivational issue. For instance, the contingencies may not be in place to support that performance over time. That is, reinforcement may not be provided for

engaging in best practice behaviors and there may be a lack of feedback when performance is inadequate.

Despite the cause of the inadequate performance, as stated by the BACB Professional and Ethics Code (2014) section 4.09, "Behavior analysts [must] review and appraise the restrictiveness of procedures and always recommend the least restrictive procedures likely to be effective" (pg. 13). For this reason, it is imperative that authors of BSPs evaluate the restrictiveness of interventions and that programs like BTCs continue to review the treatments recommended by these authors. Restrictive and intrusive strategies should only be implemented with adequate rationale and should be considered a temporary solution as opposed to long-term. Further, when implemented, there should be a plan for reduction or removal when they are no longer necessary for success as stated in section 4.11 of the BACB Professional Ethics Code (2014). Increased awareness and discussion of the problem, the use of tools like the one described in this study, and guidance provided by BTCs may increase the likelihood that authors of BSPs provide both rationale and fading procedures. Of note, not all authors of the BSPs were behavior analysts. However, Van Houten and collogues (1988) spoke across disciplines stating that individuals have a "right to the least restrictive yet effective treatment available" suggesting its importance beyond the field of behavior analysis.

Restrictive and intrusive procedures have a serious impact on client's lives. Currently there are clients who have very restrictive community access, live in a gated facility, are required to wear mechanical restraints for periods of time, have limited access to personal items, have limited privacy because staff are required to search their rooms multiple times a day, among many other restrictions. All of which are rights that many individuals experience daily and may be taken for granted. Most other individuals are not concerned about their rights being removed indefinitely. However, for individuals diagnosed with developmental disabilities and/or mental

illness, this is a possible occurrence. After the initial removal of these rights, many clients are not provided a way to receive these rights back. By implementing restrictions/intrusions only when there is adequate rationale and including fading plans for when they are no longer necessary, these individuals can regain their autonomy. For our main goal as practitioners should be to advocate for our clients by helping ensure that they are receiving the least restrictive most effective treatment available.

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Appendix A

HSIRB Approval Form

WESTERN MICHIGAN UNIVERSITY

Institutional Review Board
FWA00007042
IRB00000254

Date: October 30, 2018

To: Stephanie Peterson, Principal Investigator
Kelsey Webster, Student Investigator
Cody Morris, Student Investigator

From: Amy Naugle, Ph.D., Chair

Re: IRB Project Number 18-10-38

This letter will serve as confirmation that your research project titled "A Descriptive Analysis of Components of Behavior Support Plans" has been **approved** under the **exempt** category of review by the Western Michigan University Institutional Review Board (IRB). The conditions and duration of this approval are specified in the policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note: This research may **only** be conducted exactly in the form it was approved. You must seek specific board approval for any changes to this project (e.g., ***you must request a post-approval change to enroll subjects beyond the number stated in your application under "Number of subjects you want to complete the study"***). Failure to obtain approval for changes will result in a protocol deviation. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the IRB for consultation.

Reapproval of the project is required if it extends beyond the termination date stated below.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: **October 29, 2019**

Office of the Vice President for Research
Research Compliance Office
1903 W. Michigan Ave., Kalamazoo, MI 49008-5456
PHONE: (269) 387-8293 FAX: (269) 387-8276
WEBSITE: wmich.edu/research/compliance/hsirb

CAMPUS SITE: Room 251 W. Walwood Hall

APPENDIX B

Operational Definitions

RC-3 Supervision – Restrictions that require that a staff/parent/etc. monitor the client for any duration of time.

RC-3 Stimuli – Restrictions that prevent the client from accessing personal belongings or other tangible items.

RC-3 Communication – Restrictions that prevent a client from engaging in any mode of communication.

RC-3 Secured Living – Any restriction that requires a client to live in an environment where they are prevented from leaving as a result of a locked facility.

IC-3 Medication – An intrusive strategy in which a client has been prescribed behavior altering medication.

IC-3 Mechanical – An intrusive strategy in which the use of a physical or mechanical device is used to restrict an individual's movement.

IC-3 Privacy – An intrusive strategy that encroaches on an individual's personal space or personal items (does not include body; MDHHS, 2012).

IC-3 Bodily Integrity – An intrusive strategy that encroaches on an individual's physical body (MDHHS, 2012).

IC-5 An intrusive strategy that prevents the individual from engaging in alternative behaviors (i.e., they are not physically possible).

Example: Arm Splints (client cannot physically move their arms).
Non-example: Room Search (client can still engage in alternative behaviors).

R-1 Any explanation described by the author that linked the restrictive/intrusive strategy to any behaviors to provide rationale for that strategy.

R-2 Behaviors listed in the BSP as the targeted behaviors (i.e., they are defined).

R-3 Any assessment of the behavior providing rationale for or that describes the behaviors providing rationale for the restrictive/intrusive strategy (this can include a records review).

R-4 A listed criteria for reduction of a specific behavior.

Example: Physical aggression – Decrease to zero (100% reduction) within six months.
Non-example: Decrease all target behaviors to zero.

R-5 Data that was provided from the author of the BSP to the BTC.

R-6 Average frequency of behaviors for all behaviors providing rationale for the restrictive/intrusive strategy (up to six months of data).

Example: Arm splints are put in place as a result of SIB. Average monthly rate per month for SIB for up to six months of data.

Non-example: Arm splint is put in place as a result of SIB. Average rate per month for all target behaviors (i.e., SIB, physical aggression, food stealing) for up to six months of data.

R-7 Average frequency of behaviors for all behaviors providing rationale for the restrictive/intrusive strategy (up to six months of data) in which the score is zero.

R-8 If a specific goal is defined (see R-5) does the data (i.e., R-7) indicate that the client is meeting that goal.

R-9 Strategies that restrict a client from engaging in other appropriate replacement behaviors (i.e., they are not physically possible).

Example: Client has a freedom of movement restriction and cannot go out into the community. As a result, the client is unable to learn how to engage in appropriate alternatives while out in the community.

Non-example: Client have a freedom of movement restriction that requires that a staff must be with that at all times while they are out in the community. As a result, they can still engage in appropriate alternatives while out in the community.

R-10 Strategies to build behaviors aimed to replace those behaviors that provide rationale for the restriction (usually addresses the same function).

Example: When the client engages in physical aggression, staff prompt them to engage in their coping skills.

Non-example: When the client engages in physical aggression, staff provide neutral attention while redirecting. There are no other proactive strategies teaching coping skills or other related skills.

FP-1 Any systematic plan to reduce or terminate the use of the restrictive/intrusive strategy.

Example: When client engages in zero instances of physical aggression for three consecutive months, they will gain community access accompanied by two staff members.

Non-example: When problem behaviors decrease, restrictions will be reviewed.

FP-2 Specific criteria for fading plans (most likely a behavior or duration requirement).

Example: When client engages in *zero instances of physical aggression* for *three consecutive months*, they will gain community access accompanied by two staff members.

Non-example: When problem behaviors decrease, restrictions will be reviewed.

FP-4 Criteria for how many instances of behavior for a reduction in the restrictive/intrusive strategy.

Example: Zero instances of SIB.

Non-example: A decrease in behavior.

FP-5 Number of fading plans with a behavior requirement (see FP-4) for each behavior providing rationale for the strategy.

Example: Fading plan has criteria for both physical aggression and property destruction (all the behaviors providing rationale for the strategy).

Non-example: Fading plan has criteria only for physical aggression (physical aggression and property destruction provide rationale for the restriction).

FP-6 Behaviors in the BSP not indicated as providing rationale for the restrictive/intrusive procedure.

Example: Fading plan targets both physical aggression, property destruction, medication refusals, and therapy (physical aggression and property destruction are the only behaviors providing rationale for the strategy).

Non-example: Fading plan targets physical aggression and property destruction.

FP-7 Behaviors that would aid in decreasing the behaviors providing rationale for the strategy and/or would help maintain appropriate behaviors.

Example: Client is also required to attend all doctor's appointments, therapy, sign a contract, etc.

Non-example: Client also has to refrain from medication refusals (i.e., not a behavior providing rationale for the restriction).

FP-8 Criteria for the duration of time a behavior must be decreased and/or the quantity of successful opportunities required for a reduction or termination of a restrictive/intrusive procedure.

Example: Behavior must be decreased for *three months.* Behavior must maintain zero instances for *three consecutive outings*.

Non-example: Behavior must be decreased for a sufficient amount of time.

APPENDIX C

Fading Plan Examples

Table 8

Lighter Restriction Fading Example

Lighter Restriction	
Removal Criteria	Client must engage in appropriate behavior (i.e., not displaying any of the behaviors providing rationale for the restriction) for one month.
Rule	The lighter will be turned in to staff nightly (from 11:00pm-6:00am), which is home policy.
Resetting Criteria	The client has used the lighter to cause harm to oneself, others, and property. For this reason, the lighter restriction will be put back in place if any of the resetting target behaviors or behaviors related to the lighter occur (e.g., threatening to start anything on fire, starting anything on fire, causing harm to oneself or others with the lighter, refusing to turn the lighter in as night, etc.).

Table 9

Freedom of Movement Restriction Fading Example

Freedom of Movement Restriction (Community Access)	
Removal Criteria (Individual Goals)	**90-Minute Independent Community Access:** Client must engage in appropriate behavior (i.e., not displaying any of the behaviors providing rationale for the restriction) for three consecutive months.
	Up to four hours of Independent Community Access (i.e., the visit does not have to be four hours in duration but must be longer than 90-minutes): Client must engage in appropriate behavior (i.e., not displaying any of the behaviors providing rationale for the restriction) for three appropriate 90-minute outings.
Resetting Criteria	If client displays any of the behaviors providing rationale for the restriction, the fading plan will restart.