

**Title 9--DEPARTMENT OF
MENTAL HEALTH
Division 45--Division of
Developmental
Disabilities
Chapter 3—Services and Supports**

9 CSR 45-3.090 Behavior supports

PURPOSE: This rule sets forth requirements for providers of home and community-based services regarding supports to individuals with intellectual and developmental disabilities and assures the rights of individuals to receive best practice behavior strategies that lead to greater independence and enhanced quality of life. This rule describes the division's oversight of behavior supports, establishes behavior supports review committee, and describes the role and function of behavior support committees.

(1) Definitions.

- (A) Applied Behavior Analysis – The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior, as established in section 337.300(1) RSMo;
- (B) Behavior Analysis Services – Use of applied behavior analysis principles and technology to assist support systems of individuals with challenging behaviors to prevent those behaviors as well as teach, promote, encourage, and reinforce alternative skills and behaviors;
- (C) Behavior support plan (BSP)—A part of the individual support plan that is comprised of behavior analytic procedures developed to systematically address behaviors to be reduced or eliminated and behavior skills to be learned;
- (D) Blocking – A staff person using a part of their body to prevent an individual from inflicting or incurring harm when an individual is attempting to hit, kick, or otherwise harm the staff or another person. Use of pads, cushions or pillows to soften or prevent impact to the individual or others is also considered blocking. Blocking does not involve grasping or holding any part of the individual's body;
- (E) Challenging Behaviors - Culturally abnormal behavior(s) likely to both limit access to the community and interfere with independence and autonomy;
- (F) Chemical Restraint -as defined in section 630.005, RSMo, are medications (prescribed or over the counter) administered with the primary intent of restraining a patient who presents a likelihood of serious physical injury to himself or others, not prescribed to treat a person's medical condition;
- (G) Due process-A mandatory process in which individuals are involved and have the opportunity to voice any concerns if their rights are limited or restricted for therapeutic

- purposes. If they disagree, they have access to external advocacy. Any limitations or restrictions must have specific plan how the individual's rights may be restored;
- (H) Due process review committee-- A committee that is operated by the Division of DD or operated by a contracted provider approved by the Division. These committees review situations where individual's receiving services from the DMH rights are being limited or restricted to ensure that due process has occurred and that the individual's rights are being protected;
 - (I) Emergency Interventions - Unplanned interventions, usually involve physical restraint strategies, designed to maintain safety of the individual or others in the threat of imminent harm, used for one or two incidents until a planned intervention is developed, i.e., safety crisis plan and/or Behavior support plan. These interventions must be least restrictive and comply with statutes, rules, regulations and policies of the division.
 - (J) Emergency intervention system- also called physical crisis management programs. A formal curriculum and training program to teach prevention, de-escalation and physical restraint also called manual holds to maintain safety in emergency situations.
 - (K) Exclusion time out - the temporary exclusion of an individual from access to reinforcement, as part of a formal behavior support procedure, in which, contingent upon the individual's undesirable behavior(s), the individual is excluded from the potentially reinforcing situation but remains in the same area with others present;
 - (L) Functional Behavior Assessment (FBA) - Information-gathering process used to understand the purpose of challenging behavior. The functional assessment must be designed and monitored by a licensed behavior analyst, or licensed psychologist, counselor, or social worker trained in behavior analysis;
 - (M) Informed Consent - Consent for treatment based on certain basic elements that include: an understandable explanation and purpose of the procedure to be followed, a description of physical, emotional, or mental discomfort or risk to be expected, an offer to answer any inquiries concerning the procedure, and an explanation that at any time consent can be rescinded. Informed consent must be obtained from the guardian, and every effort should be made to obtain informed agreement from the individual;
 - (N) Individualized Support Plan (ISP) – A document that results from the person centered planning process, which identifies the strengths, capacities, preferences, needs and personal outcomes of the individual. The ISP includes a personalized mix of paid and non-paid services and supports that will assist the person to achieve personally defined outcomes.
 - (O) Individual support plan team—the individual, the individual's designated representative(s), and the support coordinator. Providers of waiver-funded services may also participate in the support plan team if such participation is requested by the individual or guardian.
 - (P) Least Restrictive procedure– A procedure that maximizes an individual's freedom of movement, access to personal property, and/or ability to refuse while maintaining safety.

The degree of restrictiveness is based on a comparison of the various possible procedures that would maintain safety for the individual in a given situation;

- (Q) Licensed behavioral support professional –individual licensed in the state of Missouri under sections (6) and (7) Section 337.315, RSMo. Licensed behavior support professionals may authorize the use of reactive strategies
- (R) Manual hold –also called physical restraint and manual restraint; any physical hold involving a restriction of an individual’s voluntary movement. Physically assisting someone who is unsteady, blocking to prevent injury, etc. is not considered a manual hold;
- (S) Mechanical Restraints – any device, instrument or physical object used to confine or otherwise limit an individual’s freedom of movement that cannot be easily removed. Locking a wheelchair, taking crutches, taking power mechanism from wheelchairs, special seat belts that cannot be removed by the individual, or other ways of restricting an individual’s mobility are considered mechanical restraints. Mechanical restraints are prohibited from use in home and community based settings. Following are not considered mechanical restraints:
 1. Medical protective equipment prescribed as part of medical treatment for a medical issue;
 2. Physical equipment or orthopedic appliances, surgical dressings or bandages, or supportive body bands or other restraints necessary for medical treatment, routine physical examinations, or medical tests;
 3. Devices used to support functional body position or proper balance, or to prevent a person from falling out of bed, falling out of a wheelchair;
 4. Typical equipment used for safety during transportation, such as seatbelts or wheelchair tie-downs; or
 5. Mechanical supports or supportive devices used in normative situations to achieve proper body position and balance.
- (T) Person Centered Planning Process--A process directed by the individual, with assistance as needed from a guardian, public administrator, the responsible party or other person as freely chosen by the individual. The process may include other individuals freely chosen by the participant who are able to serve as important contributors to the process. The person-centered planning process enables and assists the individual to access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally defined outcomes and the training, supports, therapies, treatments and/or other services become part of the service plan;
- (U) Positive Behavioral Supports - Strategies designed to support individual growth, enhance quality of life, and work toward both 1) eliminating restrictive measures by teaching and reinforcing the person’s use of appropriate skills to communicate wants and needs and 2) replacing undesirable behavior(s);
- (V) Preventative Strategies – Clearly defined protocols which describe knowledge and skill sets which providers and/or the individual must implement in order to prevent occurrences of undesirable behaviors or the use of restrictive supports while also creating increased

opportunities for success. Preventative strategies are documented in the support section of the ISP;

(W) Prohibited procedures- The following interventions are prohibited by the Division of Developmental Disabilities and are considered at high risk for causing harm.

1. Any techniques that interfere with breathing or any strategy in which a pillow, blanket, or other item is used to cover the individual's face;
2. Prone restraints (on stomach); restraints positioning the person on their back supine, or restraint against a wall or object;
3. Restraints which involve staff lying/sitting on top of a person;
4. Restraints that use the hyperextension of joints;
5. Any technique or modification of a technique which has not been approved by the Division, and/or for which the person implementing has not received Division-approved training;
6. Mechanical restraints are prohibited from use in Home and community based settings;
7. Any strategy that may exacerbate a known medical or physical condition, or endanger the individual's life or is otherwise contraindicated for the individual by medical or professional evaluation;
8. Use of any reactive strategy or restrictive intervention on a "PRN" or "as required" basis. Identification of safe procedures for use during a crisis, in an individual's safety crisis plan, is not considered approval for a restraint procedure on an as needed basis;
10. Seclusion -Placement of a person alone in a locked or secured room or area which the person cannot leave at will can only be utilized as part of an approved Behavior Support Plan. The use of seclusion time-out requires ongoing services from a Licensed Behavioral Service Provider and prior review and approval by the Regional Behavior Support Review Committee;
11. Standing orders for use of restraint procedures – unless part of a comprehensive safety crisis plan that delineates prevention, de-escalation and least restrictive procedures to attempt prior to use of restraint;
12. Any procedure used as punishment, for staff convenience, or as a substitute for engagement, active treatment or behavior support services;
13. Use of law enforcement or emergency departments cannot be incorporated into individual support plans or behavior support plans as "PRN" procedures or as contingencies to eliminate or reduce problem behaviors;
14. Reactive strategy techniques administered by other individuals who are being supported by the agency;
15. Corporal punishment or use of aversive conditioning– Applying painful stimuli as a penalty for certain behavior, or as a behavior modification technique;
16. Overcorrection strategies – Requiring the performance of repetitive behavior as a consequence of undesirable behavior designed to produce a reduction of the frequency of the behavior. Examples::;
17. Placing persons in totally enclosed cribs or barred enclosures other than cribs.
18. Any treatment, procedure, technique or process prohibited e by federal or state statute.

- (X) PRN—a medical term meaning “when necessary,” abbreviated from the Latin pro re nata;
- (Y) PRN Psychotropic Medication for Behavioral Support - Medication (pharmacologic agent) that affects a person’s mental status and is prescribed to be given according to circumstance rather than at a scheduled time. If utilized, the Behavior Support Plan/Individual Support Plan must include skill or responses to be developed to reduce the need for the PRN and must specifically describe strategies to address the situation prompting the PRN use;
- (Z) Provider –any entity or person under contract or applying for a contract with the Department of Mental Health (DMH) to serve individuals with developmental disabilities funded by general revenue or through home and community-based waivers administered by DMH;
- (AA) Psychotropic/Behavior Control Medications - Any medication that affects the person’s mental status or behaviors regardless of their diagnoses;
- (BB) Qualified Personnel – Staff persons who have received y training, demonstrated competency, and maintained required certification and understanding of the following:
 1. The Physical Crisis Management System utilized at the agency in which they are employed;
 2. The implementation of the individual’s safety crisis plan;
 3. The implementation of the Behavior Support Plan and Individual Support Plan;
 4. All requirements as a service provider outlined in the most current service definitions for providers.
- (CC) Reactive strategies- The use of immediate and short term procedures that are necessary to address dangerous situations related to behaviors that place the person or others at risk. Such procedures, if utilized as a first time response to an emergency situation. Procedures include blocking and physical restraints. This also includes responses that are more delayed such as restricting access to the community or increased levels of supervision. These are procedures used in direct reaction to the undesirable behavior as opposed to proactive and preventative strategies designed to address the undesirable behaviors in a positive fashion.
- (DD) Reactive strategy threshold-the use of three or more reactive strategies within a six month period, or two or more reactive strategies in a two month period;
- (EE) Regional Behavior Supports Review Committee (RBSRC) – A committee consisting of a chairperson who is a Licensed Behavior Analyst, employed by the division and appointed by the division director or designee, along with qualified members, whose functions include meeting expectations set forth in this rule;
- (FF) Regional Office (RO)—local offices of the Division of Developmental Disabilities serving a defined geographic region of the state;
- (GG) Restrictive interventions—The use of interventions that restrict movement, access to other individuals, locations or activities, restrict rights or employ aversive methods to modify behavior. These may also be called restrictive supports, procedures or strategies;

- (HH) Safety Assessment - assessment by the planning team and physician of an individual's physical, and/or emotional status. This includes history and current conditions that might affect safe usage of any reactive strategies, and identifies those reactive strategies which should not be used with the individual due to medical or psychological issues of safety. The safety assessment should be completed annually or on the occasion of any significant change;
- (II) Safety Crisis Plan - An individualized plan outlining the reactive strategies designed to most safely address dangerous behaviors at the time of their occurrence or to prevent their imminent occurrence;
- (JJ) Significantly Challenging Behaviors - Actions of the individual which, without behavioral, physical, or chemical intervention, can be expected to result in issues described in 1 – 6 below. Services to address these behaviors may necessitate involvement of a licensed behavior analyst or other licensed professional with appropriate training and experience:
1. Have resulted in external or internal injury requiring medical attention or are expected to increase in frequency, duration, or intensity such that medical attention may be necessary without intervention by a Senior Behavior Consultant;
 2. Have occurred or are expected to occur with sufficient frequency, duration or intensity that a life-threatening situation might result as a result of self-injury, aggression, or property destruction. Examples include excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, swallowing excessive amounts of air, or running into traffic;
 3. Have resulted or are expected to result in major property damage or destruction, value of property more than \$200;
 4. Have resulted in or are expected to result in arrest and confinement by law enforcement personnel;
 5. Have resulted in the need for additional staffing and/or behavioral/medical personal assistant services; or
 6. Have resulted in the repeated use of emergency interventions and restrictive supports.
- (KK) Threshold criterion of reactive strategy use- the use of three or more reactive strategies within a six month period, or two or more reactive strategies in a two month period;
- (LL) Time out –
1. Exclusion time-out is the temporary exclusion of an individual from access to reinforcement in which, contingent upon the individual's undesirable behavior(s), the individual is excluded from the potentially reinforcing situation but remains in the same area with others present.
 2. Seclusion time-out is the temporary and time-limited removal of an individual to an area or room in which there is limited access to reinforcement and the individual is not allowed to leave the area or room through the use of verbal directions, blocking attempts of the individual to leave, or physical barriers such as doors. or until specified behaviors are performed by the individual. Locked rooms (using a key lock or latch system not requiring staff directly holding the mechanism) are prohibited. This is sometimes referred to as a safe room or calm room.

(MM) Waiver assurances—as a condition of waiver approval by the Centers for Medicaid and Medicaid Services, states are required to collect and report performance data to measure compliance with assurances specified in the federal code of regulations at 42 CSR 441.302.

(2) Rights of individuals and assurances.

- (A) In addition to those rights described in and assured by federal and state law and regulation, all individuals served by the Division of Developmental Disabilities shall have the right to be treated with dignity and respect, to receive services in the least restrictive environment, and to be assured freedom from coercion and aversive stimuli.
- (B) All individuals have the right to proper habilitation and which shall include, but not be limited to, comprehensive medical/dental care, education, employment, recreation, specialized therapies, training, social services, transportation, self-determination or guardianship, family supports, supports to have meaningful days including employment, day habilitation services, habilitative and rehabilitative services suited to the needs of the individual regardless of age, degree of disability, or handicapping condition.
- (C) Individuals experiencing significantly challenging behaviors, reaching threshold criteria for restrictive strategies, or who have been prescribed psychotropic/behavior control medications or who have PRN psychotropic medication for behavioral support shall have access to professional supports such as counseling or applied behavior analysis. Strategies to more successfully support the individual shall be detailed in a behavior support plan that includes preventive strategies and positive behavior support strategies and has been reviewed and approved by the behavior support committee.
- (D) All individuals served by the Division of Developmental Disabilities shall have strategies that may prevent problem situations and challenging behaviors included in their individual plans of support. Preventive strategies shall meet the following conditions:
1. Must be included in all Behavior Support Plans;
 2. Should be included in the Support Section of Individual Support Plan for any individual who has had challenging behaviors in the past year and does not have a Behavior Support Plan.
 3. Preventive strategies may be developed by non-licensed team members if the behaviors of concern meets the following conditions:
 - A. The behavior has not caused significant injury or danger to self, others, or property;
 - B. The behavior has not restricted the individual's access to the community, and if the support strategies involved may typically be considered public domain by promoting a more positive environment, enriching the individual's daily routine, and teaching more functional skills but are not solely the practice of applied behavior analysis.
- (E) No individual shall experience restrictive supports without due process. Restrictive supports include but are not limited to any limitation of access to:
1. Communication with others;
 2. Leisure activities;
 3. The individual's own money or personal property;

4. Goods or services per typical routines;
 5. Access to parts of the home or the community;
 6. Communication with others; and
 7. Privacy or independence via any direct observation procedures such as continuous one-to-one staffing during times or places which would otherwise be considered private.
- (F) Individuals who are receiving residential supports who have experienced or are considered by the person centered planning team as likely to experience emergency interventions shall:
1. Have qualified personnel supporting them who have been competency trained in an emergency intervention system, who maintain current certification in the system; and
 2. Have a safety assessment and a current safety crisis plan with all support providers
- (3) Service delivery:
- (A) Individuals shall have the right to receive appropriate supports and services in accordance with their ISP and in accordance with 9 CSR 45-2.017.
 - (B) Individuals shall be integrated in and have access to the greater community in accordance with 42 CFR 441.301. The division shall ensure that services provided are of good quality and comparable to those provided to persons in the community without disabilities.
 - (C) Providers shall comply with the terms and conditions of the home and community-based waivers approved by the Center for Medicare and Medicaid Services and operated by the Division of Developmental Disabilities and the MO HealthNet DD Waiver Provider Manual.
 - (D) Providers shall not utilize prohibited procedures.
- (4) Contracted providers shall monitor and implement positive proactive strategies to reduce the likelihood that an individual will require reactive strategies or restrictive interventions. Providers shall develop processes to review usage as the threshold criteria for reactive strategy is reached.
- i. When individuals reach the reactive strategy threshold shall trigger the planning team's extensive review and analysis of the problem situations. The planning team should:
 1. Convene within 5 business days to complete the review and any modifications.
 2. Identify triggers, preventative strategies and barriers to using the least restrictive strategies;
 3. Consider the need for a functional behavior assessment, and development of a formal behavior support plan or revision of an existing behavior support plan ;
 4. Develop new or revised proactive strategies and strategies to prevent situations that are likely to result in use of reactive strategies.
 - ii. Any individual meeting the reactive strategy threshold for two consecutive quarters shall be referred to the Regional Behavior Support Review Committee for consultation. If an individual meets the reactive strategy threshold for three or more quarters in a two year period, the planning team shall request behavioral services.
- (5) Restrictive Interventions other than approved physical crisis management procedures shall not be used as an emergency or crisis intervention.

- (A) Use of restrictive procedures that meet the definition of reportable events must be reported in accordance with 9 CSR 10-5.206.
 - (B) Plans using restrictive interventions shall be reviewed by the Due Process Committee and approved by the region's Behavior Support Review Committee.
 - (C) Restrictive interventions are utilized only as alternatives to more restrictive placements and only as a means to maintain safety and allow the teaching of alternative skills that the individual can utilize to more successfully live in the community.
 - (D) The ISP must include justification for any modification(restrictions). The following requirements must be documented in the person-centered service plan:
 - 1. Identification of a specific and individualized assessed need;
 - 2. Documentation that the positive interventions and supports used prior to any modifications to the person centered service plan;
 - 3. Documentation that less intrusive interventions were tried but were not successful.
 - 4. Regular collection and review of data to measure the ongoing effectiveness of the intervention;
 - 5. Established time limits for periodic reviews to determine if the intervention is still necessary or can be terminated;
 - 6. Informed consent of the individual or their legal guardian;
 - 7. Assurances that interventions and supports will cause no harm to the individual as described in 42 CFR 441.301(c)(2)(xiii).
- (6) Behavior Support Plans (BSP) shall be developed by a licensed behavioral service provider in collaboration with the individual's support system. The techniques included, in the plan, must be based on a functional assessment of the target behaviors. The techniques must meet the requirements for the practice of applied behavior analysis under Section 337.300. to 337.345 RSMo The plan must include the following information:
- (A) Alternative behaviors for reduction and replacement of target behaviors, defined in observable and measurable terms. They must be specifically related to the individual and relevant environmental variables based on FBA;
 - (B) Goals and objectives for acquisition of coping skills appropriate alternative behaviors;
 - (C) Interventions aligned with positive functional relationships described in FBA including strategies to address establishing operations, contextual factors, antecedent stimuli, contributing and controlling consequences and physiological and medical variables; Data collected must include antecedents/triggers, description of events, duration, consequence/result, and effects of interventions. If physical restraint or time-out are used monitoring of health status will be observed and data documented for one (1) hour after the event in 15 minute intervals. Health status data will include monitoring of vital signs including pulse, visual observations of energy/lethargy level, engagement with others or other observed reactions.
 - (D) Description of specific data collection methods for target behaviors to assess the effectiveness of the strategies and data collection methods to assess the fidelity of implementation strategies;
 - (E) Data displayed in graphic format, with indications for the environmental conditions and changes relevant to target behaviors;

- (F) Proactive strategies to prevent challenging behaviors, improve quality of life, promote desirable behaviors and teach skills, that are specifically described for consistent implementation by family and/or staff;
 - (G) Specific strategies with detailed instructions for reinforcement of desirable target behaviors;
 - (H) Specific strategies to generalize and maintain the desired effects of plan, including strategies for fading contrived contingencies to natural contingencies to support system changes and maintain these strategies after BSP is faded;
 - (I) A Safety Crisis Plan if it is necessary to have strategies to intervene with at risk behaviors to maintain safety;
 - (J) If a plan includes physical restraint or time-out, specific criteria and procedures are identified;
 - (K) Target behavior(s) related to the symptoms for which psychotropic medications were prescribed and when they should be administered and the process for communicating data with the prescribing physician;
 - (L) Description of less restrictive methods attempted in the past, their effectiveness, and rationale that proposed BSP strategies are the least restrictive and most likely to be effective as demonstrated by research or history of individual;
 - (M) The method of performance based training to competency for care givers and staff providing oversight. Data will be reviewed at least monthly by qualified program staff. The qualified behavioral service provider will review data at least monthly
 - (N) Description of how plan will be communicated to all supports, and services. including the frequency with which the ISP team will receive updates
- (7) A Safety Crisis Plan must be developed after the first use of any reactive strategy or when the personal history of the individual indicates there is a likelihood that reactive strategies may be needed in the future, or where the individual's support team plans to use reactive strategies. A template for the Safety Crisis Plan is provided in Appendix A and B.
- (A) If reactive strategies are considered likely and necessary, the team shall be proactive and consider the need for more specialized support strategies in the ISP and services such as Person Centered Strategies Consultant or Behavior Analysis Services (see Medicaid Waiver service definitions);
 - (B) Procedures identified must be those identified as least restrictive and within safety parameters of the safety assessment. These will be used as a last resort after implementation of proactive, positive approaches;
 - (C) If a safety crisis plan includes physical restraint or time-out, specific criteria and procedures are identified;
 - (D) The plan must include the informed consent of the person, their parent or guardian;
 - (E) The Safety Crisis Plan will be considered a part of the Individual's Support Plan; and
 - (F) Safety Crisis Plans shall be part of any Behavior Support Plans.
- (8) Use of physical restraint and the name of the approved or nationally recognized crisis management program must be included in the individual's Safety Crisis Plan (as required in RSMo 630.175.1). Restraints shall only be used in situations of imminent harm to prevent an individual from injuring self or others. Less restrictive crisis management procedures including de-escalation techniques and environmental management should be attempted prior

to use of any type of restraint. Use of restraints are required to be included in a Safety Crisis Plan. Restraints include physical (sometimes call manual), chemical, and mechanical.

1. Physical Restraints. Techniques used to physically restrain individuals are limited to those from nationally recognized physical crisis management programs. Any internally developed or non-nationally recognized program requires approval by the Division.
 2. Requests for use of physical crisis management systems other than those that are nationally recognized must be made, in writing, to the Chief Behavior Analyst of the Division. If non-nationally recognized systems are approved and utilized, a quarterly analysis of the use of the restraint procedures and strategies to eliminate the need must be completed, with this documentation submitted to the Chief Behavior Analyst.
 3. The physical restraint technique shall be used only in the manner designed and must be formally trained to competency and staff must maintain certification as specified by the physical crisis management system.
 4. Physical restraint techniques shall only be employed for situations of imminent harm to self or others and not to protect property. Physical crisis management procedures may be used in emergency situations to maintain safety.
 5. Any improper or unauthorized use of a physical restraints or excessive application of force may be considered abuse and may prompt an investigation..
 6. Instances in which a physical restraint procedure is used as a reactive strategy shall be documented on the most current Event Management Form.
 7. Blocking is not considered a physical restraint procedure if used as defined in this rule.
- (A) Chemical restraints include prescription and over the counter medications and require the approval of the Director of the Division or his/her designee prior to implementation of these restraints. Any use of a chemical restraint must be included in an approved Safety Crisis Plan meeting the following criteria:
1. Identification of chemical restraints to be used;
 2. Written physician orders for any chemical restraints shall be time limited and for no longer than three hours.
 3. Written orders shall be placed in the individual's record and shall contain at least the following information:
 - A. Brief description of the imminent harm situation including ongoing activities, staff actions and the individual's actions that relates to the imminent harm;
 - B. Type of chemical restraint used;
 - C. The time when the order was written;
 - D. The time when the chemical restraint was first administered;
 - E. Ongoing visual observation and safety check shall occur during the time that the chemical restraint is affecting the individual.
 4. Standing or PRN orders for chemical restraints shall not be used. Specification in a Safety Crisis Plan or reactive strategies deemed safe for an individual and/or recommended as the most likely to be effective will not be considered as PRN orders.
 5. The authorized medical professional designated by the physician writing the order shall observe the individual and evaluate the situation within thirty (30) minutes from the time chemical restraints were initiated.
 6. In an emergency in which an on-site authorized physician is not available, only a registered nurse or a qualified licensed practical nurse may administer chemical

- restraints to an individual and only after receiving an oral order from an authorized physician.
- A. The documentation of such orders shall include the following:
 - I. Name of physician who gave the order;
 - II. Name of nurse who received the order;
 - III. Name of nurse who actually administered the chemical restraint – identify behaviors requiring the chemical restraint in specific terms that allow measurement;
 - IV. Anticipated effects of the medication and time frame related to the effects.
 - B. The person administering the chemical restraints shall document the information required and the physician's oral order in the individual's record or equivalent record.
 - C. The oral order shall be signed by a physician as soon as possible after the initial administration of the chemical restraint.
- (B) Mechanical restraints are prohibited.
- (9) Utilization of a seclusion time-out (or safe-room) procedure requires that there be a functional assessment of the target behavior, a behavior support plan, request to the Chief Behavior Analyst, in writing, specifying the rationale for the use of the procedure, and approval of the designated time-out area or room. The individual support plan must identify the need for such restrictive procedures and include behavioral services to support the individual to learn alternative behaviors and less restrictive supports.
- (A) A specialized crisis procedure can be approved to utilize seclusion time-out as an emergency procedure with the approval of the Chief Behavior Analyst. Policies and procedures for utilization in the specialized program should include all of the requirements for the Behavior Support Plan.
 - (B) Behavioral services must remain active during the time period in which the behavior support plan (seclusion time-out intervention) is in place.
 - (C) The Behavior Support Plan with a time-out procedure must include all elements identified in (6) of this rule as well as the following:
 - 1. Specification that only qualified personnel may use seclusion time-out for an individual under conditions set out in an approved behavior support plan.
 - 2. If the behavior support plan includes time-out, it shall be reviewed and approved by the following:
 - A. Regional Office's Behavioral Support Review Committee;
 - B. Regional Office's Due Process Review Committee;
 - C. The individual or the family, or legal guardian as appropriate; and
 - D. The Chief Behavior Analyst or designee.
 - 3. Target behaviors, operationally defined, and consistent with the function identified in the functional assessment for the target behavior;
 - 4. Description of strategies to ensure high rates of positive reinforcement and engaging activities are available for the individual making "time in" an enriched situation;
 - 5. Criteria for release from time-out and discontinuation of a time-out episode:
 - A. Release from time-out criteria is limited to no more than five minutes of calm behavior.
 - B. Total duration for the seclusion time-out episode shall be no more than one hour except in extraordinary instances (during initial stage of program) that are

- personally approved at the time of occurrence by the behavior analyst and reviewed within one business day by the region's assigned area behavior analyst.
- C. Continuous observation of the person in time-out.
 - D. Seclusion time-out will be discontinued if there are any signs of injury or medical emergency and the person will be assessed by appropriate medical personnel.
 - E. The date, time and duration of each time-out intervention shall be documented on a data sheet and on an event management form.
- (D) Time-out areas or rooms shall meet the following safety and comfort requirements:
- 1. Areas and rooms to be utilized for seclusion time-out and the procedures for the use of time-out shall be reviewed and approved by the Chief Behavior Analyst or designee.
 - 2. Continuous observation of the individual in the area shall be maintained at all times.
 - 3. Adequate lighting and ventilation shall be used at all times.
 - 4. The area or room shall be void of objects and fixtures such as light switches, electrical outlets, door handles, wire, glass and any other objects that could pose a potential danger to the individual in time-out.
 - 5. If there is a door to the room or area, it will open in the direction of egress such that the individual in the room is not able to bar the door to prevent entry.
 - 6. The door shall be void of any locks or latches that could allow the door to be locked without continuous engagement by a staff person.
 - 7. The room or area will be at least six feet by six feet in size or large enough for any individual, who will utilize the room, to lie on the floor without head or feet hitting walls or door.
- (10) The Division shall provide oversight for services provided to individuals with significantly challenging behaviors through Regional Behavior Support Committees (RBSC). The division shall establish at least two (2) RBSCs. Additional RBSCs may be established depending upon need and staff capacity.
- (A) The RBSC shall be appointed by the division director or designee.
 - (B) The RBSC shall consist of three (3) to five (5) members including:
 - 1. A chairperson who is a licensed behavior analysis employed by the division;
 - 2. A member or members of the provider community licensed to practice applied behavior analysis or who provided behavior therapy under contract with DMH prior to January, 2012 or who are working towards BCBA or BCaBA certification under the supervision of a licensed behavior analysis.
 - 3. A medical consultant or other professionals as indicated by the information under review or requested by the chairperson.
 - (C) The RBSC shall meet at least once every three (3) months, and may meet as often as needed to fulfill responsibilities.
 - (D) The purpose of Regional Behavior Support Committees shall be to promote the implementation of best practice strategies that lead to greater independence and enhanced quality of life for individuals experiencing challenging behaviors. Behavior support committees shall ensure the following:
 - 1. That waiver assurances are met;

2. That best practice behavioral services are followed;
3. That ethical guidelines are followed;
4. That behavioral strategies are least restrictive,
5. That implementation of strategies documented in the individual support plans and behavior support plans support progress toward greater independence and enhanced quality of life; and
6. That due process is given to all individuals whose ISP or BSP includes restrictive supports or procedures.

(E) The division shall establish with the RBSC review criteria to include at least the individuals with the most frequent incidents of problem outcomes for significantly challenging behaviors and those individuals whose supports include restrictive interventions including such strategies as seclusion time out, restriction of access to community, personal belongings, communication or funds.

1. Additionally, a plan may be reviewed based on a request by the members of the ISP, including but not limited to the parent/guardian, support coordinator, or Regional Director (or designee) to provide technical assistance.
2. The Regional Director and the Regional Behavior Supports Review Committee shall prioritize reviews to ensure appropriate representation based upon issues that represent regional challenges to meet identified objectives.

(11) If use of prohibited or unauthorized procedures is discovered, the following will occur:

- (A) Regional Director will be notified of the use of prohibited procedures, the agency involved, persons for whom the procedures were utilized, and reasons for use;
- (B) Regional Director will direct regional staff and Area Behavior Analyst to conduct a focused review of the agency;
- (C) If the focused review confirms that prohibited or unauthorized procedures were used, the Regional Office Director will be informed and notify the provider and support coordinator. If the procedures were included in the BSP, the provider or support coordinator will convene the planning teams to develop appropriate alternative strategies and discontinue the use of the prohibited procedures immediately. If the BSP includes appropriate protocols and the staff operated outside the scope of the plan, the provider will determine appropriate personnel action. If the prohibited procedures utilized meet the definition of either physical abuse or neglect, per 9 CSR 10-5.200, it will be reported to the Department of Mental Health investigations unit;
- (D) Area Behavior Analyst will work with planning teams to determine appropriateness of strategies and need for additional services to assist the provider to address the situations positively, proactively and preventatively;
- (E) Area Behavior Analyst will refer supports of individuals, for whom the prohibited practices have been used, to the RBSRC; and
- (F) Follow up reviews of the provider will occur to ensure that appropriate procedures and supports are utilized and prohibited practices have been discontinued for a duration determined by the Chief Behavior Analyst.

(12) Design, implementation and monitoring of behavior analysis services:

(A) Providers of behavior analysis services shall provide services only as certified and as provided by 20 CSR 20631.005-6.006 and RSMo Chapter 337.

(B) All aspects of behavior analysis services shall be integrated with other relevant services and supports being provided to the individual by the provider within the scope of authorized behavioral services.

(C) The selection of behavior analysis procedures and decisions by the provider to make environmental changes that obviate the need for the use of behavior change procedures shall be based upon information obtained through direct and indirect functional assessment or functional analysis designed to identify patterns of behavior and the functional relationships between the behavior or behaviors targeted for change and the environment. The assessment shall contain at minimum:

1. Operational definitions of all behaviors targeted for change;
2. Description of conditions under which the behavior is most likely and least likely to occur;
3. Measures of current level of behavior targeted for change;
4. Other relevant personal, social, medical, pharmacological or historical information that may impact on behavior targeted for change, if any;
5. Putative functional relationships between targeted behavior and environment; and
6. Recommendations for procedures to decrease challenging behavior and increase relevant appropriate alternative behavior.

(D) Behavior analysis services designed by the provider to decrease behavior shall include procedures for increasing functional replacement behavior, or acquisition of adaptive skills to serve as a functional alternative to the behaviors targeted for change.

(E) Behavior analysis procedures that are the least intrusive to the individual and the most likely to be effective shall be used by the provider.

(F) Medical treatment to address purely medical etiologies or physical or occupational therapies to address behaviors that are related to physical limitations shall be provided concurrent with, or prior to, the implementation of behavior analysis services by the provider.

(G) Behavior analysis services shall include strategies for maintenance and generalization of behavior change in relevant settings and criteria for termination of the interventions or services.

(H) The behavior service provider shall ensure that persons responsible for implementing, monitoring and providing behavior analysis services receive performance-based training that prepares them to properly implement the behavior analysis procedures involved, within the circumstances under which the services will be provided.

(I) The behavior service provider shall take reasonable steps to ensure data collection for behaviors targeted for increase and decrease during the entire period services are in effect

(J) Behavior analysis services plans are to be written as succinctly as is possible to effectively serve as a guide to those who will be implementing the plan.

AUTHORITY: section 630.050, RSMo Supp. 2013, and 630.175, RSMo Supp. 2014,***

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, and 2008*

***Original authority: 630.175, RSMo 1980, amended 1996, and 2008*

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