

Instructions and Requirements for the Use of Restrictive Measures in Long-Term Support Programs for Children



WISCONSIN DEPARTMENT
of **HEALTH SERVICES**

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Foundations for Supporting Children and Youth with Complex Behaviors

The Wisconsin Department of Health Services (DHS) maintains that all children and youth are entitled to live their best life and must be treated with respect regardless of complex behavioral needs. A foundational assumption is that every behavior, including dangerous behavior, has a purpose or meaning for the child or youth. Furthermore, any techniques involving coercion, including restrictive measures, are the least desirable way of addressing such behavior. Restrictive measures should be considered the method of last resort, and the provision of positive behavior supports must precede their use. The following instructions and requirements for the use of restrictive measures have been developed according to these foundational principles.

Section 1: Who is Covered by These Requirements

A primary objective of the CLTS Waiver Program is supporting children or youth enrolled in the program and their families in the community and promoting their health and safety. To advance this goal, the administrative body of the CLTS Waiver Program, the Division of Medicaid Services' Bureau of Children's Services (BCS), issues the following requirements to identify and remediate risk to a child's or youth's well-being.

These requirements apply to children and youth with a developmental disability or traumatic brain injury who meet the definition of "patient" in Wisconsin Statute § 51.61 (1) and who may be subject to the use of restraints, isolation, protective equipment or medical restraints here-in-after referred to as "restrictive measures." The coverage of these instructions includes children who have long-term support needs who are participants in the Children's Long-Term Support (CLTS) Waiver Program or the Children's Community Options Program (CCOP).

These requirements apply to items, services, and supports using CLTS Waiver Program funds, regardless of who administers the restrictive measure. If an unpaid caregiver requests to purchase items or fund services or supports through CLTS and there is a restrictive component, they must follow the restrictive measures guidelines. And, the county waiver agency—with input from the participant's family—must submit a restrictive measures application.

An unpaid caregiver is one whose services are not paid by or arranged through the department or county, often a parent/guardian or relative. The use of restrictive measures by an unpaid caregiver not using CLTS Waiver Program funds is not subject to the patient's rights protections set forth in Wis. Stat. § 51.61 and the required approval process under Wis. Admin. Code ch. DHS 94.10. It is the responsibility of the county waiver agency and provider staff to alert DHS to possible problematic uses of restrictive measures, as per the obligation set forth in the requirements of a Medicaid Waiver program to ensure participant safety.

Moreover, the inappropriate use of restrictive measures by unpaid caregivers in settings not covered by Wis. Admin. Code ch. DHS 94.10 may be considered to be abuse or neglect under Wis. Stat § 48.02. Children and youth who are receiving services for mental illness, developmental disabilities, alcoholism, or drug dependency and enrolled in the CLTS Waiver Program are also covered by the provisions in Wis. Stat. § 51.61 and have the right to be free of restraints. To address inappropriate, at-risk, or abusive situations, please see the Department of Children and Families (DCF) [Report Child Abuse and Neglect webpage](#).

For the above settings, the requirement for departmental approval for the use of restrictive measures arises from: Wis. Stat. § 50.02(2) and § 51.61 (1)(i); Wis. Administrative Code ch. DHS 94.10; and the federal requirements set forth by the Centers for Medicare & Medicaid Services (CMS) which under §1915(c) of the Social Security Act requires state agencies that administer Home and Community-Based Waivers ensure the health and welfare of waiver participants.

Failure to obtain approval for the use of restrictive measures according to the process and criteria contained in these instructions will be considered to be a violation of the child or youth's rights under Wis. Stat. § 51.61 and § 50.09 and Wis. Admin. Code ch. DHS 94 and ch. DHS 83 as applicable, by the Department of Health Services (DHS). Such failure will also be considered a violation of the terms and conditions of the state and county contract under Wis. Stat. § 46.031 and may result in a disallowance for some or all costs associated with serving the waiver participant.

Section 2: Approach to Dangerous Behavior

When challenging behavior is present, positive behavior supports must be used and documented as part of an individual service plan (ISP). Positive behavioral supports offer an approach for developing an understanding of why a child or youth engages in the challenging and dangerous behavior and focuses on supporting them in a respectful, dignified, and person-centered manner through empowerment, choice, and connections to prevent the reoccurrence of behaviors with negative outcomes. Departmentally supported best practices for supporting children and youth are outlined in Appendix B.

Service planning is an individualized, collaborative, and family-centered process, using a goal-driven and strengths-based approach to build an ISP that contains individually identified outcomes, priorities and interests. Considerations must include the child or youth's functional abilities, the physical environment, the biological influences on behavior, and all psychological and social factors that may influence behavior. Behavior supports documented in this plan must be the most positive, most effective, and least intrusive options possible for the child or youth's circumstance; they can and should be subject to adjustment as needed. There must be ongoing efforts to help the child or youth develop skills to more effectively communicate his or her needs and wishes and achieve greater independence.

Requests for the use of restrictive measures must be preceded by documented attempts to use alternative behavioral strategies and investigation into the functions of and reasons behind the child or youth's behavior. Service providers and county waiver agencies may only consider restrictive measures after less restrictive behavior support strategies have been determined ineffective in preventing the child or youth's dangerous behavior. If restrictive measures are considered, the provider must develop a behavior support plan and apply for county and departmental approval for their use as detailed in these requirements. Appendix C contains additional details and recommendations for behavior support planning.

Section 3: Prohibited Practices

The CLTS Waiver Program and CCOP may not purchase items or fund services and supports that meet any of the following criteria:

- Any maneuver or technique that does not give adequate attention and care to protection of the child or youth's head.
- Any maneuver, technique, or device that places pressure or weight on the chest, lungs, sternum, diaphragm, back, or abdomen.
- Any maneuver or technique that places pressure, weight, or leverage on the neck or throat, on any artery, on the back of the head or neck, or that otherwise obstructs or restricts the circulation of blood or obstructs an airway, such as straddling or sitting on the torso, or any type of chokehold.
- Any maneuver or technique that involves pushing into a child or youth's mouth, nose, or eyes.
- Any maneuver or technique that uses pain to obtain compliance or control, including punching, hitting, hyperextension of joints, or extended use of pressure points.
- Any maneuver or technique that forcibly takes a child or youth from a standing position to the floor or ground. This includes taking a child or youth from a standing position to a horizontal (prone or supine) position or to a seated position on the floor.
- Any maneuver or technique that creates a motion causing forcible impact on the individual's head or body or forcibly pushes a child or youth against a hard surface.
- Any use of seclusion where the door to the room would remain locked without someone having to remain present to apply constant pressure or control to the locking mechanism.
- Any item that endangers the health or safety of the participant.

Section 4: Emergency Use of Restrictive Measures

Definition of an Emergency

County waiver agencies and providers are required to obtain prior approval for use of restrictive measures from the Wisconsin Department of Health Services (DHS). DHS will make an exception to the requirement for prior approval if the situation meets the definition of an emergency use of restrictive measures.

An emergency use of restrictive measures only applies to situations that either have not occurred before or have not occurred more than two times in a six-month period and the team does not anticipate will occur again. If the team anticipates this type of situation is likely to occur again or it has occurred more than twice in a six-month timeframe, the situation does not meet the definition of an emergency use of a restrictive measure. Instead, it becomes a planned response to an expected behavior and cannot be considered emergency use. Once the provider anticipates an ongoing need for a restrictive measure, the team must request approval for its use. All future interventions to respond to such a situation require the team to go through the planning and approval process contained in these instructions and standards.

Restrictive measures may be used in emergency situations only to protect the participant or others from harm, must be the least restrictive approach possible, and must be used for the shortest time possible. Each instance of unplanned, emergency use of a restrictive measures is a reportable critical incident. A child's or youth's family and/or legal guardian(s), caregivers, and providers are all responsible for reporting threats to the child's or youth's safety or wellbeing to the county waiver agency. In turn, the county waiver agency must notify DHS of any incident or critical incident according to the requirements listed in Chapter 9 of the CLTS Waiver Manual.

Restrictive measures may be used in emergency situations if all of the following conditions are present:

- A child or youth's behavior poses an immediate threat of harm to self or others;
- There is no approved behavior plan for the child or youth addressing the planned use of restraint, isolation, or protective equipment intended to address this behavior, or there is an approved plan but it failed to anticipate a significant escalation in intensity or severity of the behavior.
- The behavior in question has either not occurred previously or could not have been reasonably foreseen to occur based on observations of the child or youth's behavior.

If an emergency occurs, provider staff should first follow emergency or crisis procedures and employ de-escalation strategies to the extent possible. De-escalation strategies are a series of steps including techniques such as offering choices, respecting personal space, allowing time for decisions, response blocking, providing redirection, graduated physical guidance, and modifying demands.

If all alternative measures tried prove to be ineffective, the emergency situation continues and is placing the child or youth or others at imminent risk of harm, the provider may use emergency manual

restraint, isolation, or protective equipment to protect the child or youth or others from harm. The restrictive measure chosen should be the least intrusive option likely to be effective. If the initial measure is ineffective, the provider may use other measures involving greater restriction. Providers should document in the participant's file the use of each measure, the reasons the provider selected the measure, and a description of why any measure was not effective. Providers may reference documentation of these explanations in preparation for future applications for restrictive measures

Provider Requirements for Use of Emergency Restrictive Measures

Most provider agencies already have written emergency or crisis procedures for responding to many unanticipated situations. If the provider lacks crisis procedure policy but serves people covered by these instructions, they must develop such a policy. The provider agency's written policy for such situations must be available on request from any state staff involved in the restrictive measures review process. The policy should be accessible to all direct service staff and be the subject of training for all such staff.

County waiver agencies are responsible for ensuring that providers meet the following requirements in order to use emergency restrictive measures:

- **Written policy:** Each provider agency must have a written policy describing the process used in the event staff need to use an emergency restrictive measure. The policy must identify the specific person or type of position that is authorized to select and initiate the emergency use of the restrictive measure and is responsible for related procedures when an emergency situation is present. At minimum, the policy must require those using the measure to obtain eventual authorization by the agency director or designee as quickly as possible after its use. Such authorization must be limited to the specific current emergency episode. The provider is required to document the date, time, and method of all attempts at notifying the appropriate parties.
- **Release criteria:** The team ensures the provider agency staff person, director, or the director's designee has established child- or youth-specific release criteria for the specific situation. Release criteria documentation must include a description of any conditions that must be present prior to releasing the child or youth. The criteria for release should also identify cues that are unique to the participant for determining if he or she appears to be calm and is no longer a danger. Any threats to a child or youth's health or well-being caused by the measure during its application require the immediate release from the restrictive measure and notification of supervisory personnel or medical personnel (if the child or youth requires immediate medical care).
- **Reauthorization of use:** Direct support staff using the measure must obtain reauthorization for the use of the measure from the agency director or designee if an emergency recurs after release from restraint.
- **Time limits:** The agency director or designee may initially authorize use of restraint or isolation in emergencies for up to 15 minutes. After 15 minutes, the provider must assess the degree that the

child or youth's behavior has de-escalated. In the event that dangerous behavior continues, an additional 15 minutes of restraint or isolation are permitted.

- Training of staff: The provider must ensure direct support staff applying the restraints or protective equipment is adequately trained and able to use the techniques competently. The provider should proactively seek the assistance of external professionals when needed to assist staff in responding to the emergency. The provider should outline the training curriculum in the written emergency procedure policy.
- Measure employed must be monitored: The use of the emergency restrictive measure must be monitored in a manner that conforms to the requirements in these instructions and a standard including collecting data on the frequency per incident and the duration (number of minutes), each restrictive measure was used.
- Involve law enforcement when necessary: If the dangerous behavior during the emergency reaches a point where staff believes they are not able to manage the situation effectively or safely and that harm to the child or youth, staff, or others is likely to result, staff may call law enforcement authorities for assistance. DHS recommends proactive discussions occur with local law enforcement and the team develops a plan that details the desired outcome for situations involving law enforcement.

Section 5: Restrictive Measures Requests, Oversight, and Assistance

In all nonemergency situations, the county should have a system in place for addressing the perceived need for using restrictive measures. This section describes the required features of such a system.

Preparing the Restrictive Measures Request

Providers should work with representatives of county agencies early in the process to ensure all requirements and expectations are met.

The application the provider submits to the county must conform to the requirements and expectations in these instructions plus any additional requirements stipulated by the county. The department expects that the application will have been internally reviewed and approved by provider managers before submittal.

There are preconditions to the department considering for review a behavior intervention plan and restrictive measures application. These same preconditions should be used by county waiver agencies in conducting their approval process as well.

The preconditions that must be addressed before submitting an application under this process include:

- The use of restrictive measures must involve the general supervision of an interdisciplinary team;
- The application must be developed with the cooperation and approval of the team and must be complete and accurate;
- The application must be approved by the child or youth's guardian, if any; and
- The application must have documented approval by the child or youth's physician.

The approvals listed above must be obtained before the application is submitted to the county waiver agency and DHS. The child or youth's guardian must give written, informed consent approving the plan for use of these measures. Consent entails approval of the overall approach proposed to deal with planned emergencies described in the child or youth's behavior support plan. Consent is not required in advance for every separate use of the specified intervention proposed.

To obtain informed consent from the child's or youth's guardian, the provider must describe the anticipated impact of the restrictive measure proposed and explain why it was chosen. The provider should have a written protocol describing how this information will be conveyed to the participant and/or their guardian. If necessary, translation services for people with sensory disabilities or people with limited English language proficiency must be made available to ensure that consent is truly informed.

The application package must be sent first to the county waiver agency and, if approved, to the department. County staff conducting the review and approval process must be different from those who may have assisted the provider in preparing the application. This process will be explained in more

detail in the next section. The application must include a copy of the behavior support plan, a completed application form using the correct form and all documentation referenced in the form. The completed application form and accompanying documents must conform to all requirements in these instructions.

The form used for restrictive measures applications is: [Request for Use of Restraints, Isolation or Protective Equipment as Part of a Behavior Support Plan \(F-00926\)](#).

If the plan calls for a medical restraint, the form used is: [Request for Use of Medical Restraints \(F-00926A\)](#).

Training of Involved Staff

All staff involved in the administration of restraints and seclusion must receive adequate training. Training must occur prior to implementing any restrictive measure and, at minimum, annually. Assurance of training of all individuals involved in the administration of restrictive measures is the responsibility of the team. Training must include proactive strategies to intervene at the first signs of tension to prevent further escalation, information about how to use specific restrictive measure techniques or devices properly, and how to inspect the device or equipment. DHS does not require a specific training curriculum for direct support staff on techniques of restrictive measures, but DHS may request information from teams on the training curriculum used and on the qualifications of the individuals conducting direct support staff training to determine how teams are addressing this need.

Section 6: County Waiver Agency Restrictive Measures Oversight

County Waiver Agency Behavior Intervention Oversight Committee

If the provider or county waiver agency intends to pursue the development of a behavioral intervention plan that includes the use of restrictive measures, a local behavior intervention oversight committee must be organized at the county level. These committees have the responsibility for reviewing all proposals for the use of restrictive measures and making the decisions pursuant to the requirement for local approval contained in Wis. Admin. Code ch DHS 94.10.

The committee should also serve as a local technical assistance resource for the county waiver agency and provider staff involved in proposing, approving or implementing restrictive measures and other forms of behavior supports. County support and service coordinators involved in assisting the provider develop the plan and application should be different staff than those on the behavior support and oversight committee.

County waiver agencies and providers are encouraged to organize broad based, multi-county or regional behavior support and oversight committees to perform these functions. Multi-county regional committees may be more effective, having more experience from the higher volume of applications as well as the ability to focus training on its members. Furthermore, a regional committee may also promote greater separation from the county waiver agency staff who assist the application process.

County Approval

Wis. Admin. Code ch DHS 94.10 requires county approval of any request for the use of restrictive measures in situations where the county is the placing agency. Counties must therefore have an approval process in place for all providers and participants covered by this requirement. This includes children or youth who are funded by, placed by, and have their services coordinated and/or managed by one county but who physically reside in a different county. Responsibility for approval at the county level lies with the county providing the funding and/or placement and coordination services. Each county may establish submission requirements for their own approval process independent of state submission requirements described later in this section but must, at minimum, use the same application form and criteria for approval contained in these instructions. Counties may enhance their process so long as criteria for approval do not conflict with those in these instructions.

To obtain county approval, the required form must be completed by the provider and any assisting county staff. The county uses its own approval process to review the application packet and can:

- Approve the proposal as submitted.
- Approve the proposal with conditions.
- Deny the proposal.

- Return it due to incompleteness.

The county must approve the provider's application before an application can be submitted to DHS. DHS will not accept, comment on, or make decisions about an application if a provider seeks departmental review prior to sharing with a county. Provider requests for department input, advice or technical assistance from the department must also come through the county.

It is recommended that the county approval process parallel the department's process. Counties must have a written and easily understandable description of their decision-making and review process for providers to reference. The process must describe all of the elements of the review including:

- Identification of the established point of contact for applications.
- How and by whom the application will be reviewed at the local level (type of position, not necessarily the specific people).
- How the results of the review will be communicated to the provider.
- How the county will transmit approved applications to the provider.

Communication of the county's decision to providers must be in writing, identifying each measure reviewed, describing reasons for a denial and including explanation of any conditions of approval. It is recommended that the communication provide guidance on what can be done by the provider to remedy the returned or rejected application. This communication must be signed by someone in a management position, designated by the director of the county agency.

Section 7: DHS Review Process

Level 5 Exceptional Treatment Foster Homes

If a child's team determines that a child participating in the CLTS Waiver Program requires placement in a Level 5 Exceptional Treatment Foster Home ("Level 5 Foster Home") and has dangerous behaviors that warrant the use of restrictive measures, application for the use of restrictive measures is required to be submitted to the DCF inbox (DCFL5FHRequests@wisconsin.gov) and approved by both the Department of Children and Families (DCF) and DHS. The application for certification and child placement in a Level 5 Foster Home is reviewed and approved through the DHS/DCF Exceptions Panel. Applications for the use of restrictive measures for a child in a Level 5 Foster Home must be submitted using the required CLTS Waiver Application form and follow all requirements provided in this Instructions and Requirements for the Use of Restrictive Measures Manual. All components of the application and plan must be complete. The submitted restrictive measure application will follow the same requirements as all restrictive measures for the CLTS Waiver Program and will be reviewed by the review panel at DHS. The use of restrictive measures with a child placed in a Level 5 Foster Home must be approved by both DHS and DCF.

There are conditions of the approval for the restrictive measure monitored throughout the life of the approval. The approval for the use of restrictive measures can be rescinded by the joint DHS/DCF Exceptions Panel. If a restrictive measure is used outside the scope of an approval and/or results in an injury, agencies must submit an incident report to DHS CLTS Waiver Program and DCF Level 5 Exceptions Panel within prescribed timelines. Each approval for a restrictive measures plan includes submitting regular restrictive measures usage data to the joint DHS/DCF Exceptions Panel as a condition of approval. For further information, refer to [Level 5 Exceptional Treatment Foster Home Guide to Certification and Placement](#).

Submitting the Application

After receiving approval through the county waiver agency review process, the application and county approval letter must be submitted electronically to DHS via the CLTS email inbox (dhsclts@wisconsin.gov). However if a child placed in a foster home, then the application should be submitted to DCF for review by the DHS/DCF Exceptions Panel. The Restrictive Measures Lead for the CLTS programs will review the application packet and will inform the county of anything missing in order to submit to the Review Panel for the CLTS programs. Applications lacking county approval will be returned.

Review Panel for Long-Term Support Programs for Children

For participants in the CLTS Waiver Program, DHS review is conducted by the Restrictive Measures Review Panel for long-term support programs for children. The review panel is comprised of the Restrictive Measures Lead for long-term support programs for children and other staff from DHS selected based on the county of residence of the child or youth for whom the application is being submitted.

Approval of all restrictive measures will be based on the following:

- The completeness of the application.
- The degree to which the application reflects the requirements and expectations contained in these instructions.
- The appropriateness of the restrictive measure proposed as a response to the identified medical or behavioral need.
- Whether the restrictive measure is the least intrusive means of maintaining safety.
- The ability of the proposed restrictive measure to protect the health, safety and welfare of the child or youth.

DHS Review Decisions

Following review of the submitted application, the Restrictive Measures Review Panel's decision may be:

- Approval without conditions
- Approval with conditions
- Denial
- Denial pending more information

DHS will send a review decision letter to the county waiver agency within 15 business days of receipt of a complete application unless other arrangements are made. Complex cases may take longer, but any anticipated delays will be communicated to the county waiver agency.

Approval

Approval letters will state the date the application was received, the specific measures approved, and the approval period. Except for medical restraints, all approvals of restrictive measures must have an expiration date. Medical restraints may be approved one time and do not require reapproval. Expiration dates for all other restraints will be individually determined but will not exceed one year.

Denial

Denial letters will convey the specific reasons for denial and will describe the parent or guardian's appeal rights. Disagreements with any action, decision or condition of the department are subject to appeal by the parent or guardian via the process discussed in Section 11.

Denial–Pending Additional Information Notices

If DHS requires more information or clarification prior to approving or denying a request, DHS will send a denial–pending additional information notice to the county waiver agency. The letter will detail the specific additional information needed or necessary modifications to the application. The team will be required to respond to the questions and requests for additional information within 15 business days. The county waiver agency must request an extension from the Restrictive Measures Lead for long-term support programs for children if the team needs additional time to gather the requested information.

If DHS does not receive a response within 45 business days of the date of denial–pending notice, the request is considered withdrawn. If the team wishes to pursue approval after that date, the county waiver agency must submit a new request.

Use of Unapproved Restrictive Measures

The use of a restraint without approval is not permitted except for emergencies as described in Section 4. Use without approval is a violation of a child or youth’s rights and will likely result in a disallowance for costs incurred while the unapproved restraint was in use under Medicaid Waivers. DQA may take enforcement actions as well. Except emergencies as discussed, approval of the planned use of restrictive measures by DHS must be obtained prior to implementation. In complex cases, the panel may request and/or require expert consultation regarding specific treatment issues or to resolve concerns as part of this process. Use of special consultants may delay the approval.

Section 8: Criteria for Approval of a Restrictive Measures Request

Submitted applications should reflect a complete process, adherence to all stated requirements, and an approvable behavior support plan. The team must cooperate to develop and approve the submission, which includes authorization by the county waiver agency, providers and the participant's guardian. Authorization from a medical provider is required for all restrictive measure requests. The team must obtain this permission annually, and list all requested restraints as well as their contraindications on the application. Furthermore, requests concerning isolation and seclusion must adhere to the information provided in Appendix D.

In addition to these criteria, DHS and counties will base their approval of restrictive measures request on all of the following:

- The plan details use of the measure only when the child or youth's behavior actively presents an immediate danger to self or other people. Dangerous behavior does not include property damage, yelling, throwing objects, verbal threats, or other behaviors that are only disruptive.
- The restrictive measure proposed is the least restrictive approach available to achieve an acceptable level of safety for the child or youth. This applies to each measure proposed and to the interactive effects, if any, of all such measures.
- There is documentation that less restrictive interventions have been tried and were not effective in preventing the occurrence of dangerous behavior.
- The plan specifies frequencies and intervals for monitoring an individual during use of a restrictive measure for signs and symptoms of adverse effects on their health and well-being specified. The frequency of monitoring must not be less than once every 15 minutes and must be clearly indicated.
- The plan outlines the maximum duration of continuous application of the measure for each instance of use and the maximum duration of continuous application of all restrictive measures combined.
- The plan outlines the release criteria from the measure. Staff must release the individual from the measure when the criterion identified in the plan is met.
- The staff adequately ensures the health, safety, welfare, dignity, and other rights of the child or youth while the restrictive measure is in use.
- The provider does not use restrictive measures in lieu of adequate staffing or for staff convenience.
- All staff involved in the use or monitoring of the restrictive measure must receive training prior to implementation of the measure. Staff must receive ongoing training on the use of the measure, at minimum, annually.
- The team's supervision, monitoring plan, and backup arrangements are adequate to ensure effective responses to unanticipated reactions to the measure that might arise.
- The request contains a reasonable plan for reducing or eliminating the need for using the measure as soon as possible. The plan must indicate that restrictive measures are a temporary strategy to maintain safety and should describe replacement skill development or benchmarks to be used for reduction in usage.

- The plan includes a measurable benchmark that would lead the team to consider eliminating the use of the measure in an effort to determine whether the plan is effective.
- The plan includes a specific monitoring plan with timelines for review of restrictive measure usage data as well as the benchmarks described in the elimination and reduction plan.
- The request includes information related to how protective equipment or other types of devices are checked regularly to ensure they remain in good working condition.

When, as a result of the state-level review of the application for a restrictive measure, it is determined that equipment and adaptive devices do not function as restraints, providers must still assure the health and safety of the subject of the application by making sure the device or equipment is functioning optimally and as intended. In this case, the requirements outlined in Chapter 4 of the CLTS Waiver Manual apply.

Section 9: Continuous Monitoring of Restrictive Measures

The approval process for restrictive measures is a continuous process that does not end with the approval decision by DHS, and should always guarantee that participants are protected from harm. The team must continually monitor the use of any approved restrictive measure according to a child- or youth-specific plan that must accompany each submission. Continuous monitoring should address whether or not less restrictive supports are available as an alternative to use of the restrictive measure. A monitoring plan is a necessary condition for approval of a Restrictive Measure application and should be reassessed, at minimum, annually. These plans must ensure that:

- The measure is used properly and for appropriate amounts of time, as detailed in the application.
- That staff inspect and clean the device regularly, documenting the content and date of such inspections in the provider's record.
- The provider agency's director, the county waiver agency, and DHS are notified of each episode of restraint, isolation or protective equipment.
- A child or youth placed in restraint, isolation or protective equipment is continuously monitored for signs of adverse effects. All children and youth must be re-evaluated for de-escalation after 15 minutes, and all staff observations should be identifiably documented.
- The nature of observation must be adequately described in the plan and include descriptions of physical proximity, hearing range and related factors. The use of seclusion requires continuous, eyes-on monitoring be included in the plan.
- Staff receive appropriate training according to these standards.
- Any adjustments made to the measure are appropriate and documented.
- Providers develop a plan for monitoring medical restraints, including specific provisions on staff training, maintenance and monitoring of the device.

Monitoring Reports

Data collection is a requirement for all approved restrictive measures. The provider must collect data that includes the frequency per incident and the duration (length of time) each restrictive measure was used. The data must also indicate which specific restrictive measure staff used and the precipitating (antecedent) events that resulted in the use of the measure. Data summaries are to be submitted on a monthly basis via email to the CLTS inbox (dhsclts@wisconsin.gov). Level 5 reports should be submitted to the DCF inbox (DCFL5FHRequests@wisconsin.gov). Data summaries may be requested more frequently as determined by DHS.

This monitoring report must include written descriptions of the results of the use of the measure observed during the monitoring process. Contents must include:

- A description of the condition of any equipment used as observed during the inspection done to ensure the equipment is in good working order.
- Verification that only trained staff implemented the behavior intervention plan.

- Descriptions by the trained direct support staff about the child or youth's response to the intervention.
- Descriptions of the specific episode of use of the measure including an assessment of the effectiveness of the measure being used for the behavior in question in light of the plan.
- Notations concerning the possible need for any modifications to the behavior intervention plan.
- Progress on the plan to reduce/eliminate the use of the restrictive measure.

The report must be maintained in both the provider's and county's participant files.

Temporary Suspension or Permanent Revocation of Approval

DHS may revoke approval at any time upon a determination there has been a negative impact on the child or youth. This may be either temporary or permanent. Cause for such an action may include a finding that there has been a substantial deviation in some aspect of the plan for using the measure or failure to adequately meet the conditions of approval. DHS or the county waiver agency may also amend approval by imposing new or additional conditions, if the need is determined. The county waiver agency must submit new imposed conditions of approval to DHS and the conditions are subject to DHS review and approval.

DHS or county waiver agency staff may impose suspensions on-site without written notification. The entity imposing the on-site suspension verbally must follow up with a written notification confirming the suspension, explaining the reasons for the suspension, and describing the action the provider needs to take in order to remove the suspension in a timely fashion. The entity imposing the suspension must send the written follow-up to the provider (with copies to the other approval bodies) within five business days of the county waiver agency or DHS verbal order suspending approval, even if DHS or the county waiver agency has lifted the suspension before the notification is delivered.

On-site suspensions take effect immediately. Continued use of the restrictive measure is a violation of the child or youth's rights. The county waiver agency must maintain the written notification of suspension and the associated provider notes in the child or youth's file. Approval authorities will not accept grievances of suspensions; if the entity imposing the suspension does not find sufficient evidence to lift the suspension, the provider will have to resubmit an application in order to use the measure.

DHS intends suspensions of approval to be temporary pending further fact-finding and review. County waiver agencies should consider suspensions an interim step toward either restoration of the approval or towards revocation. DHS and waiver agencies must remove suspensions if the provider corrects the problem situation.

After the suspension, the county waiver agency will conduct an investigation to determine if the reasons for the suspension have merit. If the results of the investigation indicate that the restrictive measure is not effective, is being misused, or is having unanticipated harmful effects, approval of the use of the measure will be revoked. The county waiver agency must complete fact-finding for a suspension within 30 business days of the initial notice of suspension.

If the results of the investigation substantiate the suspension, the county waiver agency must notify DHS. DHS will communicate revocation of the approval of the measure in writing. Notices will provide the reasons for the revocation and include grievance rights for all parties involved. DHS prohibits the provider from using the measure when approval has been suspended or revoked. If the provider continues intent to use the same restrictive measure, the process for obtaining approval must start over.

Discontinuing the Use of the Restrictive Measure

Providers will be required to discontinue the use of a restrictive measure if the team determines the use of the restrictive measure is not effective or no longer necessary. Within three business days following this decision, the provider must submit written notification to the county waiver agency, who in turn is responsible for notifying DHS via email the discontinuation date and discontinuation reason for the previously approved request.

Section 10: Renewing Applications for Restrictive Measures

Approval for all behavioral restrictive measures will expire no later than one year from the date of approval. In some instances, the review panel may approve a request for less than one year.

The county waiver agency must submit a renewal request if an approval for the use of a restrictive measure is requested after the initial approval period. The county waiver agency must submit the renewal 30 business days prior to the previous approval expiration date. The renewal application occurs through the same process outlined in the previous sections of this document. The form used remains the [Request for Use of Restraints, Isolation or Protective Equipment as Part of a Behavior Support Plan\(F-00926\)](#), but the renewal application should not be a mere copy of the original, and must reflect appropriate updates and differences. It must also include a summary of restrictive measures usage during the approval period. When the renewal is submitted, the Restrictive Measures Review Panel for the long-term support programs for children will review the renewal application and determine the continued appropriateness of the requested measures.

Section 11: Contesting Department and County Decisions

All actions and decisions made by counties and by the department with respect to restrictive measures are subject to appeal if there is disagreement with the decision. Appeals can come from participants and/or their guardians. If the guardian does not approve the measure, it cannot be used. Providers and county waiver agencies may not appeal restrictive measures decisions. Decisions regarding Level 5 Foster Homes are not appealable—an approval to use restrictive measures is only allowable under an exception to ch. DCF 56 requirements, and exception decisions are not appealable.

Participants have the right to appeal decisions related to restrictive measures. Each county has already developed a written description of their grievance process and protocols for explaining participant rights, when the participant or guardian wishes to appeal decisions of the county related to any right covered by Wis. Stat. § 51.61 and Wis. Admin. Code ch. DHS 94 including the right to be free from restrictive measures. These instructions rely on that process for hearing and resolving participant complaints at all levels. This process is detailed in Chapter 8 of the CLTS Waiver Manual and the mandated reporting requirements found in Wis. Stat. § 48.981.

Section 12: Summary of Documentation Requirements

Required Documents for Application

The following items are required elements of a complete application for DHS review:

- County waiver agency letter of support
- Child or youth's individual support plan for the CLTS Waiver Program
- Behavior support plan or medical support plan
- Pictures or literature outlining each proposed restrictive measure
- Physician's order, signature on the application form, or letter of support
- All applicable signatures (child or youth, guardian, county waiver agency, waiver provider, and others who helped develop the plan)
- Complete application form:
 - Personal Summary (description of services, support systems, interests, dislikes)
 - Health Considerations (diagnoses, health concerns, height and weight, medication list, health providers)
 - Target Behaviors (description, intensity, frequency reported as an average or range, patterns, triggers)
 - Previously Attempted Methods (support strategies, outcomes)
 - Review of current and proposed strategies (proactive strategies, description of need for restrictive measures, risks and benefits)
 - List or proposed restrictive measures
 - Description or picture of proposed restrictive measure
 - Purpose of measure
 - Plan for implementation (where, when, maximum length of time, release criteria)
 - Description of proactive and less restrictive measures preceding restraint or seclusion
 - Plan to reduce or eliminate the use of restrictive measures including measurable benchmarks
 - Training Description (initial training, ongoing training, trainer name and credentials, duration of training, documentation of training)
 - Monitoring plan (summary of data collection process, description of how plan will be monitored, identification of the frequency of the review)

Requirements for County Waiver Agency and Provider Records

In addition to the items listed above for the application submitted to DHS, the child or youth's record or file must include the following information for each request for restrictive measures including restraints, isolation or protective equipment. Some information must be kept in the records held by both the CWA and the provider.

County Waiver Agency Records

Behavior Intervention Plan Development

- The support and service coordinator on the team should document the content of technical assistance and outside consultations conducted including the content of discussions and decisions resulting from the assistance in the participant's record. The documentation should identify the professional who provided the assistance, contain a description of their credentials and the results of assessments and recommendations.
- The support and service coordinator's summary of the interdisciplinary team's discussion of assessment results and decisions on supports.

Participant Behavior Intervention Plan

- The team's description of the frequency, intensity, and duration of any dangerous, challenging behavior(s) that appear along with any data summaries or graphs prepared for this purpose (see creating supportive environments in Appendix B for details of what needs to be documented).
- The behavior intervention plan must identify and discuss each type of restrictive measure selected for use, why that measure was selected, how it relates to the child or youth's challenging behavior and identify all behavior specialists involved in the use of the measure. The plan must describe ways in which the use of the measure proposed can be reduced or eliminated over time
- The required release criteria must be documented. Documentation must include a description of the specific targeted behavior(s) that must cease and any other conditions that must be present before the child or youth is released.

Incident Reporting and Emergency Use

- Assurance that all unplanned, emergency uses of restrictive measures are reported by providers to county waiver agencies, who in turn submit reports to the department as per the requirements in Chapter 9 of the CLTS Waiver Manual.

Application Review and Approval Process

- Counties must have a written description of their review and decision-making process for providers to reference describing all of the elements of the review, including the people or positions who serve as points of contact. Please refer to Section 5 for details of documentation requirements.
- The letter approving the use of the restrictive measure and any letters denying the use of the measure must be kept in the child or youth's file.
- The written notification and provider notes associated with any suspension or revocation of the approval

Provider Records

Emergency Procedures

- Providers must have a written policy, accessible to all staff, on how they will deal with emergency situations when people they serve exhibit unanticipated challenging behavior.
- The required notification of the provider agency's director or his or her designee to obtain authorization for the continued emergency use of the measure chosen must be documented including the date, time and method of all attempts at notification of the director.

- Assurance that all unplanned, emergency uses of restrictive measures are reported by providers to county waiver agencies, who in turn submit reports to the department as per the requirements in Chapter 9 of the CLTS Waiver Manual.

Participant Behavior Intervention Plan

- The team's description of the frequency, intensity, and duration of any dangerous, challenging behavior(s) that appear along with any data summaries or graphs prepared for this purpose (see creating supportive environments in Appendix B for details of what needs to be documented).
- The behavior intervention plan must identify and discuss each type of restrictive measure selected for use, why that measure was selected, how it relates to the child or youth's challenging behavior and identify all behavior specialists involved in the use of the measure. The plan must describe ways in which the use of the measure proposed can be reduced or eliminated over time.
- The required release criteria must be documented. Documentation must include a description of the specific targeted behavior(s) that must cease and any other conditions that must be present before the child or youth is released.

Staff Training and Plan Monitoring

- Training of provider staff involved in the application of a restrictive measure for a specific child or youth must be documented in that participant's file or record and must be available upon request.
- The individualized protocol for provider reporting on the use of the measure to the county and to the department including a description of the content, frequency and recipients of these reports.
- For mechanical restraint and protective equipment, the monitoring plan for the use of the device including documentation of the inspection of the device. Documentation must include the date of the inspection, findings and the identity of the person doing the inspection. When using the device, the following must be documented:
 - Date, time and location the measure was used.
 - Reason for using the measure.
 - If the use was for an emergency, any less restrictive measure used, attempted or considered first.
 - Person authorizing the measure each time it is/was used and/or required authorization.
 - Time the measure was initiated and time use ceased.
 - A description of the child or youth's condition every fifteen minutes while restrained or isolated or every thirty minutes if protective equipment was used.
 - A description of any adjustments to the measure made by the provider.
 - Name(s) of staff implementing the procedure and their signature on the notes.
 - Name of the staff continuously observing the procedure.
 - Name of person providing the required documentation.
 - Post release status/actions.

Suspension or Revocation of Approval

- The written notification and provider notes associated with any suspension or revocation of the approval of a measure, which must be maintained in the participant's file.

Section 13: Transition from Children's to Adult Long-Term Care

When a CLTS Waiver participant has an approved CLTS restrictive measures application at the time of transition, the following procedures must be completed:

- The county waiver agency must inform the adult long-term care program of the approved CLTS restrictive measures application.
- When the young adult transitions to an adult long-term care program (from CLTS to Family Care, Partnership or IRIS), the CLTS approval is valid for 90 days after enrollment.
- If the provider intends to continue to use the approved restrictive measures, the Managed Care Organization (MCO) or IRIS Consultant Agency (ICA) will work with the provider to gather necessary information to submit a request for adult long-term care approval, during the initial 90 days of enrollment. All applications for adult long-term care programs must follow the procedures and meet the approval criteria as described in the [Restrictive Measures Guidelines and Standards](#) for adult long-term care programs.

The county waiver agency and adult long-term care program must work together to ensure a smooth transition between the approved CLTS restrictive measure and the approval process for the adult restrictive measures application. The CLTS restrictive measure plan ends when the young adult has an approved adult restrictive measure application.

Appendix A: Definitions

Behavior intervention oversight committee: A “behavior intervention oversight committee” is a group of people appointed or designated by the director of a county agency who are responsible for the review and approval of any behavior intervention plan that proposes the use of a restrictive measure. Members of this committee may not act on proposals from any provider with which they have an affiliation.

Behavior Support Plan: A written document intended to assist the child or youth in building positive/desired behaviors to replace or reduce the child or youth’s challenging behavior.

Behavior Specialist or Qualified Behavior Specialist: A person who:

- Worked in the DD field for five years or more, two of which at a professional level, in a position that addressed challenging behavior. A person who worked in a related field (e.g. mental health) may also be approved as a qualified behavior specialist;
- Has an appropriate BA/BS level degree, Master’s degree, other advanced degree above the level of masters or equivalent experience in a field related to human services such as psychology, social work, behavioral disabilities or rehabilitation psychology;
- Has received training in behavioral psychology, positive behavior support, behavioral approaches/learning styles or other relevant areas

Behavior Supports: Behavior supports refer to the components of a child or youth’s environment intended to encourage behaviors that replace challenging or dangerous behaviors and help the child or youth attain their best quality of life. Behavior supports may include, but are not limited to, teaching the child or youth methods to communicate better with others, expanding the opportunities for developing relationships, improving the quality of living environments, or other clinical interventions.

Dangerous Behavior: Dangerous behavior refers to behavior that places the participant or any other person at imminent, significant risk of physical injury. Presence of dangerous behavior is the threshold for consideration of any proposed restrictive measure.

Emergency: An emergency, as it relates to restrictive measures, means an unanticipated situation has occurred where a child or youth suddenly engages in dangerous behavior, placing themselves or others at imminent, significant risk of physical injury, or exhibits signs known to be precursors of such behavior for the child or youth. This may include the appearance of a behavior that has not happened for years or has not been known to occur before or it could include current behaviors that suddenly and unexpectedly escalate to an intensity the team has not seen before.

Interdisciplinary Team: Interdisciplinary team means a group of people involved in the life and support of the child or youth. The team must include the participant, the participant’s guardian,

the participant's support and service coordinator, and representatives of the provider agency and placing agency. It may include, if possible, the participant's physician and other involved professionals involved with the support of the child or youth and others who are significantly involved in the participant's life.

Isolation: Isolation is the involuntary physical or social separation of a child or youth from others by the actions or direction of staff, contingent upon behavior. The following are not isolation:

- Separation in order to prevent the spread of communicable disease; and
- Cool-down periods in an unlocked room when the child or youth's presence in the room is completely voluntary and there are no adverse consequences if the child or youth refuses to go to the room.

Manual Restraint: A manual restraint, including physical holds and escorts, involves one or more people holding the limbs or other parts of the body of the child or youth in order to restrict or prevent their movement. DHS does not consider the following actions to be manual restraints or restrictive measures:

- Holding a child or youth's limbs or body to provide support for the achievement of functional body positions and equilibrium, such as supporting someone to walk or achieving a sitting or standing position.
- Holding a child or youth's limbs or body to prevent him or her from accidentally falling.
- Use of self-protection and blocking techniques in response to aggressive behaviors.
- Use of graduated guidance, assisting the child or youth to move, but not restricting body movement, as part of an approved intervention.

Mechanical Restraint: Mechanical restraint is the application of a device to any part of a child or youth's body that restricts or prevents movement or normal use/functioning of the body or body part to which it is applied and that cannot be easily removed by the child or youth. The following are not considered mechanical restraints:

- Medical restraints.
- Mechanical supports.
- Seat belts, bed rails and transportation safety devices such as stretcher belts, intended to prevent a child or youth from accidentally falling during transport.
- Devices authorized by an appropriate health care professional to aid in the treatment of an acute medical condition.

Mechanical Support: A mechanical support is any apparatus used to provide proper alignment of a child or youth's body or to help a child or youth maintain their balance. Mechanical supports include but are not limited to, postural supports, position devices, and orthopedic devices. The team must use a qualified professional to design a plan for use of mechanical supports in accordance with principles of good body mechanics, with concern for circulation, and with allowance for change in position. Mechanical supports must not impair or inhibit visual or auditory capabilities or prevent or impair speech or other methods of communication.

Medical Restraint: Medical restraints are any apparatus or procedure that restricts the voluntary, free movement during a medical or surgical procedure or prior to or subsequent to such a procedure for a participant with an ongoing medical condition to prevent further harm or to aid in recovery, or to provide protection during the time a medical condition exists.

Protective Equipment: Protective equipment includes devices that do not restrict movement but do limit access to one's body and are applied to any part of a child or youth's body for the purpose of preventing tissue damage or other physical harm that may result from their behavior. Protective equipment includes but is not limited to:

- a. Helmets, with or without face guards.
- b. Gloves or mitts.
- c. Goggles.
- d. Pads worn on the body.
- e. Clothing or adaptive equipment specially designed or modified to restrict access to a body part.

Provider or provider agency: An individual or agency that receives payment from a Medicaid funded long-term support program to provide direct support services to a child or youth.

Restraint: Restraint means any device, garment or physical hold that restricts the voluntary movement of or access to any part of a child or youth's body and cannot be easily removed by the child or youth.

Restrictive Measures: The term used to encompass any type of manual restraint, isolation, seclusion, protective equipment, medical procedure restraint, or restraint to allow healing as defined in these instructions.

Seclusion: Seclusion is a form of isolation in which the child or youth is physically set apart by staff from others through the use of locked doors. Seclusion does not include the use of devices like "wander guards" or similar products that may also involve locking doors.

Appendix B: Supporting Children and Youth with Complex Behaviors

When challenging behavior is present, behavior supports used must be documented as part of the individual service plan. Service planning is an individualized, collaborative, and family-centered process, using a goal-driven and strengths-based approach to build an ISP that contains individually identified outcomes, priorities and interests. Considerations must include the child or youth's functional abilities, the physical environment, the biological influences on behavior, and all psychological and social factors that may influence behavior. Behavior supports documented in this plan must be the most positive, effective and least intrusive options possible for the child or youth's circumstance; they can and should be subject to adjustment as needed. There must be ongoing efforts to help the child or youth develop skills to more effectively communicate his or her needs and wishes and achieve greater independence.

An interdisciplinary team must be organized for each participant to implement the process described in these instructions. The team may include county and provider staff and its purpose is to develop and oversee the behavior intervention plan. This includes identifying and overseeing the use of behavior support strategies and behavioral interventions utilized for the child or youth. The team is required to follow all applicable requirements, procedures and strategies discussed in these instructions.

The following strategies must be tried prior to considering the use of restrictive measures.

Assessing Factors Related to Challenging Behavior

All behavior serves a function. As such, the first action that the interdisciplinary team must take is to obtain additional information about the child or youth and the nature and function of the challenging behavior. The team must have an understanding of the behavior, including knowing in what situations the behavior is most likely to occur. In order to gain useful and essential information about the factors associated with the child or youth's challenging and dangerous behaviors, the team may assist with and perform a variety of assessments. Technical assistance and/or formal outside assessments should be conducted as needed; technical assistance may be provided by physicians, psychiatrists, nurses, "qualified behavior specialists," (see Appendix A), speech therapists, psychologists, or mental health specialists. The support and service coordinator (SSC) on the team must document the content of these discussions and decisions resulting from technical assistance in the participant's record. Documentation should identify the provider of technical assistance; contain a description of their credentials and the results of assessments or recommendations.

Assessments may include:

- **Medical and health assessments** determine whether any illnesses, injuries, conditions, efficacy of current treatments or medications, pain concerns, or dental health issues affect, contribute, or even cause the challenging and dangerous behavior.
- **Quality of life assessments** determine the extent to which a child or youth is not living their preferred lifestyle. Such assessments should consider the amount of control the child or youth has over their immediate environments and whether they live the way they desire. This includes whether the amount of independence the child or youth has during daily activities is acceptable to them; how much access the child or youth has to friends, family, and places in the community; and the extent to which these factors influence behavior.
- **Environmental assessments** determine if factors in the child or youth's physical environment cause or contribute to the challenging behavior. These may include noise level, space, attractiveness, and cleanliness; access to desired materials or possessions; opportunities to make decisions and choices about the physical environment; the responsiveness of others present in the places the child or youth frequents; and the child or youth's communication style and how housemates, friends, family, staff, and others communicate and interact with them.
- **Functional assessments** identify the purpose or function of the child or youth's challenging and dangerous behavior. This assessment may include an analysis that systematically manipulates and studies antecedent and consequent events, which may influence the child or youth's behavior. This analysis helps the team to understand the function of the behavior.
- **Psychiatric assessments** identify if a psychiatric condition is present, identify the extent to which it may influence the dangerous and challenging behavior, identify if psychotropic medication may be recommended, and determine whether changes or additions in current medication are necessary.
- **Other assessments**, such as a trauma, sensory evaluation, speech and language, communication, hearing, happiness, psychological, or psychological needs assessments, help to determine if there are other factors that may be influencing or causing the child or youth's dangerous and challenging behavior.

After assessments have been completed, the interdisciplinary team must gather available information in order to examine trends and evaluate the effectiveness of interventions. This data collection serves a twofold purpose:

- Functions as a tool to help identify new and emerging behaviors, potential triggers, and successful ways to respond.
- Determines the effectiveness of the supports and interventions when the team incorporates known patterns and trends into a plan.

The team should collect and analyze data on behaviors, as this information is critical to the development of a behavior support plan and its ongoing evaluation. For example, does the data indicate behaviors targeted for decrease are in fact decreasing and behaviors targeted for increase are increasing? If the goals of the behavior plan are not met (or at least showing some improvement), the team's hypothesis for the function of the behavior may be incorrect and

further assessment is needed or some of the planned strategies and interventions are ineffective and need to be revised. Reviews may also involve monitoring the collected data to determine whether staff utilize and follow the plan as intended.

Furthermore, it is important that the child or youth's team keep a recorded description of challenging behavior. It should identify, define and describe each specific kind of behavior and discuss why it is challenging or dangerous. It should also identify the location(s) and environment(s) where each behavior typically occurs and discuss events (if known) or changes in life circumstances that appear to trigger or are associated with each behavior. Finally, the description should indicate how other people respond to each behavior. The team should make sure to include a record of the frequency, duration, or intensity of each behavior and discuss whether or not there have been any recent changes.

After all assessments occur, the team must identify and employ behavior support strategies to address the behavior(s). The SSC must document a summary of the interdisciplinary team's discussion of assessment results and their decisions on supports in the child or youth's file or record. This material will be needed for any future application for the use of restrictive measures and will enable the team to review how a situation develops over time.

Creating Supportive Environments

Before implementing restrictive measures, the interdisciplinary team must create supportive environments for the child or youth. This may include changing lifestyles according to the child or youth's preferences; building or strengthening significant relationships with family, friends or staff; and assisting the child or youth to more effectively communicate so he or she can express wants and needs. The interdisciplinary team may also consider altering the physical environments in which the child or youth lives, attends school, studies, works, and/or spends their day. They may consider ways to modify routines or schedules of activities.

Enhancing the environment may involve building the skills of family members, provider agency staff and others. If needed, the county waiver agency and provider may revise or provide additional supports appropriate to the situation. Changing a child or youth's environment may completely avoid the need for a restrictive measure. The child or youth's interdisciplinary team is expected to adjust and readjust the child or youth's environment as necessary.

The interdisciplinary team must be continuously aware of environmental triggers of challenging behavior(s) that appear; these should be documented in writing and kept in the child or youth's file along with any data summaries or graphs prepared for this purpose. Maintaining documentation provides a history for all those giving care to the child or youth. This information may also be required for the application for restrictive measures.

Developing Behavior Support Strategies

Based upon the assessment information obtained, the interdisciplinary team must next identify and implement the most appropriate behavior support strategy(ies) available. These strategies are intended to reduce the occurrence of the challenging behavior as soon as possible. These strategies must be the most positive, least restrictive, and least intrusive of the effective options. The interdisciplinary team should consider one or more of the following behavior support strategies:

- Determine if any needed medical interventions should be arranged to help eliminate or treat any conditions contributing to the child or youth's challenging behavior. Such interventions may include initiating or changing medications to eliminate pain or to treat a physical condition; initiating or changing treatments prescribed for an illness or condition, and/or adjusting the child or youth's life style or self-management to support desired health outcomes.
- Determine if any adjustments to the child or youth's support plan need to be made. These would be intended to assist the child or youth to do more things he or she wants to do or live their daily lives differently. This could include developing a different schedule of activities, finding a more suitable school or work situation, and modifying their home environment. Furthermore, the child or youth may achieve greater independence in daily activities given the opportunity to: develop new relationships, engage in preferred activities, eliminate barriers preventing child or youth from accessing friends and family, change housemates and/or direct care staff and modify supports.
- Based on the assessment information, determine if any environmental changes are needed to minimize factors contributing to the child or youth's challenging behavior. Such changes may include altering the physical environment to reduce noise, increasing space and/or ensuring access to preferred items. Other possible changes include eliminating undesired activities; changing schedules; bettering staff and youth communication; and increasing the child or youth's control over activities and his or her environment.
- Determine if any psychiatric services should be used to improve or stabilize a diagnosed psychiatric condition.
- Determine if behavior instructions should be developed to help organize staff. In general, behavior instructions should include descriptions of the behavior, the circumstances in which the behavior is likely to occur, the signs that occur prior to the behavior, best response strategies given the specific child or youth, as well as ways the staff can encourage the expression of more appropriate responses.

The interdisciplinary team must select and implement one or more of these behavior support strategies appropriate for the child or youth in question. Implementation must involve any necessary professionals. The interdisciplinary team must identify the person(s) responsible for

implementation as well as designate someone to document all decisions concerning the behavior support strategies, the timeframes for their implementation and the effectiveness of each strategy used, according to documented metrics.

The manner of record-keeping may be determined by the involved professional(s) and/or the interdisciplinary team; DHS does not require any specific record keeping format. However, descriptions of the behavior support strategies and their effect on the child or youth must be clear to an informed outsider.

The professional(s) responsible for a specific behavior support strategy must regularly review its implementation and effectiveness and assess the child or youth's progress according to the expectations specified in the behavior support plan. Written review schedules must be included in the child or youth's service plan and must be provided to the SSC. The SSC and interdisciplinary team are expected to review the implementation and effectiveness of each behavior support strategy according to the behavior support plan.

Based upon these periodic reviews, the SSC, involved professionals, and interdisciplinary team should initiate changes in the behavior support strategies if necessary.

Developing Behavior Support Plans

All behavior, including challenging and dangerous behavior, has a purpose and meaning for the child or youth. Teams must treat children and youth who exhibit challenging behaviors that may cause harm to themselves or others with respect and as individuals entitled to a high quality of life.

A behavior support plan is a written plan intended to provide unique strategies or specific protocols as a method to build on positive behaviors and replace or reduce a challenging behavior. This may include improving communication, enhancing relationships, or using clinical interventions. The purpose of the plan is to ensure the team supports the child or youth in the most effective manner possible, while understanding cultural and personality differences, maintaining self-worth, opportunity, and respect. The plan focuses on being mindful, family- and participant-centered, and trauma-informed, while supporting the child or youth in the least restrictive and most integrated manner possible.

Positive behavioral supports offer an approach for developing an understanding of why a child or youth engages in the challenging and dangerous behavior and focuses on supporting them in a respectful, dignified, and person-centered manner through empowerment, choice, and connections in order to prevent the reoccurrence of behaviors with negative outcomes.

Behavior support plans provide caregivers a structure to strategize support in a way that is unique to a given child or youth. Preparation of a behavior support plan can be a valuable forum for gathering input from everyone involved. Once complete, a behavior support plan has numerous uses. For ongoing staff, the plan is a behavioral snapshot that is useful as a summary

of current support strategies, as well as a future gauge of progress. For new staff, the plan provides information about the unique needs of the child or youth. A behavior support plan can serve as a detailed written record of the team's work to support a child or youth.

In order for children and youth to attain and maintain the highest quality of life, the support team must provide each participant with positive, proactive, and consistent support and understand the social, physiological, medical, and environmental influences to challenging and dangerous behaviors. The goal of any positive support strategy is to improve quality of life. A plan meets this goal by teaching the participant skills or strategies that increase their ability to meet their own needs and thereby increase the child or youth's autonomy. Approaches outlined in the plan must be flexible and incorporate, as appropriate, a full integration of social, emotional, environmental, occupational, intellectual, spiritual, and physical wellness. It is through this holistic and balanced plan that the child or youth and support team can maximize strengths, preserve rights, learn and enhance skills and tools, maintain resilience, and create positive social change to fit the child or youth's needs, preferences, and outcomes.

Although the plan will assist in reducing the likelihood of challenging and dangerous behavior through replacement of adaptive and desirable behavior, the main intention is to devise a consistent caregiver approach that best supports the child or youth's well-being. Details of what an appropriate behavior support plan should include are found in Appendix C.

Appendix C: Components of Behavior Support Planning

DHS recommends incorporating the following best practices in the development of a behavior support plan:

- Assembling the support team and brainstorming: It is necessary to have input from all parties providing support to the child or youth for the team to best understand what the child or youth is trying to convey through their behavior and to create support strategies that will actually work for this unique child or youth. Team members bring different and valuable information based on their relationship with the child or youth.
- Describing the challenging and dangerous behavior (also referred to as target behavior):
Things to consider:
 - What are the behaviors of concern?
 - What would you see and hear during the behavior? What does the behavior look and sound like for this specific child or youth? (Include specific statements, sounds and movements the child or youth uses.)
 - How long does the behavior last? How often does it occur? Does the child or youth repeat the behavior?
 - What need is the child or youth trying to fulfill? (Escape, avoidance, attention, stimulation, pain relief.)
 - What emotions does the child or youth connect to the behavior?
- Discussing situations and circumstances where behaviors are likely to occur (such as triggers and meaning). Questions to ask:
 - Have the child or youth's physical needs been addressed by staff?
 - When is the behavior most or least likely to occur? (Confrontation, under- or over-stimulated, specific activity, specific request from others, power struggle, specific time of day.)
 - Where is the behavior most or least likely to occur? (Home, day program, outing, doctor visit.)
 - With whom is the behavior most or least likely to occur? (Staff, family, peers, strangers.)
 - What activities are most or least likely to produce the behavior? (Transition, familiarity, routine.)
 - Are there positive or negative stressors? (Family visit, holiday, hungry, tired, in pain, ill.)
- Noting behavioral signs and signals that occur prior to the behavior:
 - Does the child or youth change their tone of voice or content of language? (Yelling, mumbling, negative self-talk, threats.)

- Repeated questioning of others or refusal of task? (Power struggles.)
 - Does the child or youth have a change in facial expression or body language? (Glaring, staring, grimacing, pouting, arms closed, stomping.)
 - Is there a change in activity or engagement level? (Pacing, fidgeting, invading personal space.)
 - Are there signs the child or youth is over or under-stimulated? What are the potential causes (no activity, large crowd)?
- Identifying how staff should respond to the child or youth when the behavior occurs such as:
 - Engage with the child or youth by using appropriate eye contact.
 - Use a nonthreatening approach and engage in de-escalation strategies.
 - Be positive and be personalized in the approach.
 - Suggest the child or youth go to another area to calm.
 - Direct staff to not react to certain behaviors, as appropriate.
- Questions the team should consider when developing the staff's verbal and physical responses:
 - What self-soothing and self-calming strategies does the child or youth know?
 - What calming strategies can staff assist with?
 - What can staff say in the situation?
 - How should staff deliver the message? Include specific examples of what usually works with the child or youth. What approaches should staff avoid? (Power struggles, dismissal, complaining, lack of empathy.)
 - What amount personal space does the child or youth prefer?
 - How should the staff position themselves to maintain safety?
 - What restrictive measures techniques are approved as part of the plan? What are the criteria for use, maximum amount of time, criteria for release, and documentation required if used? (May not be applicable to all behavior support plans.)
 - What are emergency procedures if additional staff or police intervention is needed?
 - Should the staff and the child or youth engage in a discussion of behaviors after the incident is over?
- Identifying how staff can support and engage the expression of safer, alternative behavior:
 - What is the best approach to interacting with the child or youth? (Rapport, nonverbal communication, staffing pattern.)
 - What types of praise, reassurance, and positive support does the child or youth like?
 - What type of activity does the child or youth like? (Quiet, social, long or short duration, physical, or sedentary.)
 - What stress coping mechanisms does the child or youth know? What new coping mechanisms can staff teach the child or youth? When is the best time to practice new coping mechanisms? Include sensory integration if it is beneficial to the child or youth.
 - What are the child or youth's likes and dislikes? (Objects, food, smells, type of music.)

- What type of environment does the child or youth prefer? (Lighting, temperature, number of people, noise level.)
- What does a consistent routine or timely communication about routine changes look like for the child or youth? Does the child or youth need gradual introduction of new information, new routines, or a new residence?
- Is there a reward or incentive program for positive reinforcement of appropriate behavior (tangibles or special activities)? Does the incentive program cause stress or anxiety for the child or youth? Is everyone involved following the incentive program the exact same way?

Appendix D: Information and Requirements Specific to Isolation and Seclusion

This appendix defines, clarifies, and outlines any specific requirements for the use of isolation and seclusion.

Isolation

Isolation is the involuntary physical or social separation of an individual from others by the actions or direction of staff, contingent upon behavior. DHS does not consider the following examples of situations isolation or a restrictive measure:

- Staff separates a child or youth from others to prevent the spread of communicable disease.
- A child or youth goes to another area to cool down, their presence in that room or area is voluntary, and there are no adverse consequences to the participant if he or she refuses to go there. If a behavior plan includes a directive to a child or youth that he or she go to another area to calm down, it must be clear if this a suggestion the child or youth may refuse without any adverse consequences.
- A child or youth decides on their own, without any suggestions or prompting from staff, to go to another area, this is voluntary and does not constitute isolation. If staff suggests to a child or youth that he or she should go to another area to calm down and the child or youth chooses to go, this is also voluntary and does not constitute isolation.

Seclusion

Seclusion is a restrictive measure in which staff physically set the child or youth apart from others inside a room using locked doors equipped with a pressure-locking mechanism. Seclusion does not include the use of devices like “wander guards” or similar products that may also involve locking doors. Except as provided in this memo, DHS does not permit the use of seclusion as a form of behavior modification or as a consequence for noncompliance. The use of seclusion is only permitted as a response to a behavior that involves an imminent risk of harm and for the shortest duration possible to maintain safety. Examples of appropriate use of seclusion are to ensure safety of the participant and others due to prolonged physical aggression or to clear an area of harmful items, such as broken glass. The behavior support plan must indicate the method staff uses to transport a child or youth safely to seclusion.

Locking someone in any room where the door would or could stay locked is not permitted under any circumstance. Pursuant to Wis. Stat. § 51.61 (1)(l)(1),

... if the person's [child or youth's] behavior intervention plan indicates that the use of seclusion by the use of an approved locking mechanism³ is the least intrusive method and appears to be the most likely effective intervention and this measure is approved by the county and department, the provider may use this method. The provider is required to evaluate the continued efficacy of the intervention plan and the use of the measure at intervals of not less than once every month after each use or according to a schedule required by any or all of the approval entities.

³Approved locking mechanisms include only those requiring the constant application of pressure or control.

When a provider submits a request to use seclusion, information should be provided as to whether it is a newly constructed seclusion room or has previously been inspected and approved. The minimum acceptable standards for a seclusion room are:

- The room must be at least the size of a small bedroom so there is sufficient space for the child or youth to move.
- Features are in place to allow staff to engage in continuous visual monitoring of a child or youth in the room, such as an observation window with ceiling-mounted mirrors or video cameras.
- The room must have adequate ventilation, heating, and cooling.
- The locking mechanism must be a pressure-locking device, such as magnetic locks or another mechanical device that requires the continual presence of support staff to apply pressure to keep the door lock engaged.
- Padding of the walls and floors is required in the room if the child or youth is likely to engage in self-harm (such as head-banging or hitting walls) to the extent that such behavior could cause significant injury if the padding was not present.
- There must be efforts to ensure the child or youth would not be able to reach or damage any light fixtures in the room (such as recessed lighting or high ceilings).
- There must be protective covering over any electrical outlets in the room.
- There must be protective covering or specialized windows in place to ensure the child or youth would not be able to break any windows in the room.
- If a mirror is located in the room to ensure staff can see all areas of it, the mirror must be made of a non-breakable material or have protective covering around it to prevent the child or youth from being able to break the mirror.