Comprehensive Personal Planning and Support Policy (CPP&SP)

February 4, 2005

Government of Saskatchewan

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SECTION 1: APPLICATION AND IMPLEMENTATION OF POLICY

Introduction

This policy applies to:

- Approved Private-service Home (APSH) Proprietors
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  Regional Supervisor
  Community Service Worker
  Program Development Consultant
  Valley View Centre Staff
- Community-Based Organisations (CBOs)
- Individual Service Providers

APPROVED PRIVATE-SERVICE HOME PROPRIETORS

Responsibility

APSH Proprietors in providing day-to-day supports to the individuals under their care shall abide by the policies contained in this document.

Interpretation

CLD staff will ensure that all APSH Proprietors are familiar with this document and include the document as part of the orientation process.

COMMUNITY LIVING DIVISION

Responsibility

CLD staff shall abide by the policies contained in this document.

Within CLD, a number of staff interact closely with CBOs, APSH Proprietors and Individual Service Providers that provide supports to participants with intellectual disabilities. When these supports are observed by CLD staff as not consistent with the policies outlined in this document, the staff shall:

- Bring concerns to the attention of the CBO, APSH Proprietor or Individual Service Provider, and gather pertinent information.
- Inform the Regional Supervisor in writing; the Regional Supervisor will provide support as necessary.
- Document concerns in the appropriate file within seven working days.

- Following a review of concerns with the CBO, APSH Proprietor or Individual Service Provider, a plan will be developed to address the issue.

- Staff shall keep the Regional Supervisor informed and the Regional Supervisor has final responsibility to ensure the issue is dealt with.

The above actions are not meant to preclude any relevant legislation or government policies, such as Section 16 (1)(2) of *The Child and Family Services Act*, *The Participant Abuse Policy, CLD's Policy/Protocol for the Investigation of Abuse and Neglect Involving Adults with Mental Disabilities*, and the *APSH Program Participant Abuse Policy*.

Various community staff positions within CLD have different responsibilities with respect to this policy.

Regional Supervisor

Responsibility

Regional Supervisors are responsible for the orientation of new staff, and are often involved in program related consultations with staff and community service providers. The Regional Supervisor has the responsibility of ensuring contract compliance of the CBOs in their region, and ensuring policy compliance of APSH operators and Individual Service Providers in their region.

Interpretation

Regional Supervisors shall orient staff to the policies of this document. This document shall be included in the orientation package for each new staff member. The policies outlined shall serve as a guideline for Regional Supervisors in all program-related consultations, recommendations, and decisions.

Community Service Workers

Responsibility

In the context of case management, Community Service Workers will observe practices, respond to requests for assistance and provide guidance resulting from the implementation of person-centred planning processes.

Interpretation

When asked for assistance in program or planning areas, Community Service Workers have a dual responsibility:

- to determine what methods are presently in use and provide feedback on the appropriateness of these in relation to the policies of this document; and

- to uphold the policies in the offering of any suggestions with respect to personal planning, decision-making and behaviour support interventions and skill development interventions.

The details of such consultation, as well as the follow-up plan, must be documented in the participant's file.

Community Service Workers will ensure that APSH Proprietors and Individual Service Providers are familiar with and follow the policies in this document.

Program Development Consultants

Responsibility

Program Development Consultants shall follow the policies as outlined in this document.

Interpretation

Program Development Consultants provide leadership and support in the design and implementation of developmental/behavioural programs. This work occurs in the context of consultation with service providers, families, and CLD staff.

Valley View Centre Staff

Responsibility

In the provision of personal supports to people with intellectual disabilities, Valley View Centre (VVC) staff shall abide by the policies contained within this document.

Interpretation

All staff of VVC will be familiar with the policies contained within this document. Other VVC policies regarding the provision of personal supports to people with intellectual disabilities will be consistent with the policies contained within this document.

COMMUNITY-BASED ORGANISATIONS

Responsibility

As part of their contractual obligation to the Saskatchewan of Community Resources and Employment, CBOs will implement the policies contained within this document.

CBOs may have existing policies that meet the spirit and intent of the policies in this document. In this case CLD and the CBO may agree that there is no need to re-draft CBO policies to exactly mirror the policies in this document.

Interpretation

CBOs will ensure that all staff and board members are familiar with the policies related to this document. CBOs will also include the policies related to this document as part of the orientation process for all new staff members

This document recognises the unique position of the Early Childhood Intervention Program (ECIP) regarding the nature of their relationship to families. While ECIP staff is guided by these policies in the design and delivery of supports to families, it is the family that makes the final decision about the support offered to their children.

Individual Service Providers

Responsibility:

Individuals providing CLD-funded individual support services for participants shall abide by the policies contained in this document.

Interpretation

CLD staff will ensure that all individual service providers are familiar with this document and include this document as part of their orientation process.

SECTION 2: PROTECTION OF PERSONAL AND HEALTH INFORMATION

This policy recognises that the protection of personal and health information is governed by the following pieces of legislation:

- *Freedom of Information and Protection of Privacy Act*
- *The Health Information and Protection Act*

Accordingly, staff, agencies and service providers will be guided by the following principles:

- Where it is not reasonably practicable to obtain consent from the participant, the sharing of personal information may only be made for the provision of health or social services to the participant and only if the disclosure of the personal information will clearly benefit the health or well-being of the participant

- Personal information will only be disclosed when the person to whom the information is to be disclosed agrees to use the information only for the purpose for which it is being disclosed, and not to make a further disclosure of the information

- Personal information will only be disclosed for the purpose of arranging, assessing the need for, providing, continuing, or supporting the provision of, a service requested or required by the participant

- Policies and procedures will be in place to restrict the disclosure of personal information to those persons who require the information to carry out a purpose for which the information was collected

- All parties shall have in place and shall follow reasonable security policies and procedures

SECTION 3: DEFINITIONS

Aversive procedures:	Stimuli or activities applied in response to behaviour that the participant perceives as physically or psychologically painful or harmful
Challenging behaviour:	Behaviour that others may find disruptive, unusual and/or offensive but is not a threat to the physical well-being of others
Comprehensive Behaviour Support:	A four-component support strategy that aims to facilitate comprehensive lifestyle changes through the application of ecological changes, positive programming, focused support and reactive strategies
Core group:	The group of people who know and care about the participant and are committed to supporting her[1] (the participant decides who constitutes this core group)
Dangerous or harmful behaviour:	Any attempted or actual conduct of a person that causes, or presents an immediate risk of, bodily hurt
Ecology:	The relationship between individuals and other individuals, and between individuals and their environments
Key person:	Person designated by the participant and the core group as the fixed point of responsibility for identified actions
Participant:	Individual who receives direct services from the organisation or service provider
Person-centred planning:	Refers to the planning of co-ordinated supports that assist the participant to realise her goals, dreams and aspirations to enhance her development and quality of life When working with children, Person-centred Planning refers to the planning process around the family as well as the planning process around the child
Policy:	A formalised course of action required meeting a specific standard
Principle:	A fundamental truth, law, doctrine or motivating force
Procedure:	Method and manner by which the policy is implemented
Service provider:	Any individual, agency or organisation that is under contract to Saskatchewan Community Resources and Employment, Community Living Division to provide supports to individuals with intellectual disabilities
Standard:	A level of excellence or attainment regarded as a measure of adequacy
Supports:	"Resources and strategies that aim to promote the development, education, interests and personal well-being of a person and that enhance individual functioning […] services are one type of support provided by professionals and agencies" (AAMR, 2002, p. 15)
Supported Decision-Making:	"A process of acting with an individual to discover their values, interests, talents and gifts in order to support them to choose the way they want to live their life" (Bodnar & Coflin, in press)

1. For ease of reading, the pronouns *she* and *her* refer to participants of either gender.

SECTION 4: PROGRAM POLICY

PRINCIPLES

- Actions reflect the equal worth of all people
- Each person has unique and shared intellectual, spiritual, social and physical needs
- All interactions convey respect for the value and gifts of each participant
- The participant is provided the choice of varied opportunities for optimal learning and growth
- Opportunities for each participant are consistent with the range of what is available to and experienced by others in their community
- Optimum learning, growth and change take place in enriched environments with people who respect and value the participant

HUMAN RIGHTS AND ETHICAL CONSIDERATIONS

This section addresses the protection of the participant's rights and the responsibility of the service providers to support her in an ethical and respectful manner.

POLICY 1: All supports provided shall recognise the participant's rights and reflect ethical practices.

Considerations:

Protection of the participant's rights, as outlined in the *Canadian Charter of Rights and Freedoms, the United Nations Convention on the Rights of the Child* (1990), the *Saskatchewan Human Rights Code* and criminal and civil law is of utmost priority. Appendix A contains a brief description of the legislation that addresses human rights issues.

Practices are be considered ethical when they respect the participant's human rights and dignity, and are consistent with the policies, considerations and appendices contained within this document.

POLICY 2: Service providers shall interact with participants in a supportive and respectful way.

Considerations:

Recognition and acceptance of a participant's preferences, decisions, strengths and differences is essential. A service provider's written and verbal communications with the participant and others shall reflect this support and respect.

POLICY 3: Participants shall be provided with the support that they need to make decisions.

Considerations:

Participants have the right to make their own decisions.

Where assistance is required, a supported decision-making process (such as the one described in Appendix B) will be used to assist participants in making decisions.

When legal consent is required and the participant is unable (does not have the capacity) to provide that consent, a supported decision-making process may need to be supplemented through one of the following:

- Financial decisions made by an appointed Trustee under *The Public Trustee's Act*
- Health care decisions made under Section 16 of the *Health Care Directives and Substitute Health Care Decision Makers Act*
- Personal or property decisions made under *The Adult Guardianship and Co-decision-making Act* where that authority has been granted to the guardian or co-decision-maker.

Guardians and co-decision-makers may use a supported decision-making process to reach a decision on matters within their authority.

Family consent is required for children under the age of 16 years.

POLICY 4: Any act or omission that causes a participant to experience physical, emotional, or sexual harm, loss of individual rights, or the misuse of their personal property shall be prohibited.

Considerations:

Service providers are aware of what actions constitute abuse and neglect and are aware of their responsibility for their own behaviour as well as that of their peers in ensuring people are treated with dignity and respect.

Appendix F contains additional relevant information:

- A list and description of the abuse policies applicable to CLD and services funded by CLD (these policies define abuse and describe responsibilities with respect to the prevention of and response to allegations of abuse)
- A list and description of prohibited actions

POLICY 5: Procedures perceived by a participant to be aversive shall not be used with that participant.

Considerations:

Aversive procedures are stimuli or activities, applied in response to a behaviour that the participant perceives as physically or psychologically painful or harmful.

Any response to a participant's behaviour has the potential of being perceived by the participant as aversive, even interventions generally considered positive. A determination needs to be made regarding whether the participant perceives a procedure or event as aversive. Assessing the individual's reaction to the procedure or event may assist in making this determination.

Appendix F contains additional relevant information:

- A list and description of the abuse policies applicable to CLD and services funded by CLD (these policies define abuse and describe responsibilities with respect to the prevention of and response to allegations of abuse)
- A list and description of prohibited actions

PERSON-CENTRED PLANNING

This section addresses person-centred planning. Person-centred planning is a process through which all aspects of the participant's life are considered. The participant determines what is meaningful to her. Decisions may range from day-to-day concerns such as what to have for breakfast to larger, more encompassing decisions such as where to live and work. The participant has the right to decide and direct the process (see Policy 3, and Appendix B). The service provider has the responsibility to respect participants' decisions and to provide support.

POLICY 6: A person-centred planning process shall be used as a means of supporting the participant in deciding and planning her goals and supports required.

Considerations:

The participant is the centre of all activity.

- Plans, decisions, actions and supports are guided by and reflect the vision of the participant
- Options are authentic and within the realm of the participant's understanding

Accountability for all actions is to the participant.

- Accountability is facilitated by clearly written objectives, plans, responsibilities and time frames
- The environment in which a participant lives is designed, moulded and shaped to fit the needs of the participant

Planning is supported by complete and accurate information.

- Information relevant to the participant is helpful planning for appropriate supports. This information may include assessment/analysis of the participant's lifestyle preferences, sensory-motor, cognitive and communicative abilities and medical, social and emotional needs

Planning is an ongoing process with regular reviews to ensure the provision of appropriate supports. These reviews must occur at least once every two years.

A person-centred planning process shall be used to support the participant when moving to a different home.

Appendix C contains a planning protocol that may be used when planning with a participant to move to a different home (this appendix is an update to a prior document entitled "Comprehensive Planning Process: Protocol and Standards," September 1997). This protocol may be adapted for other situations that require intensive planning.

POLICY 7: The person-centred planning process shall involve the participant and a core group of people who know and care about the participant and are committed to supporting her.

Considerations:

The participant decides who constitutes the core group (refer to policy 3 and Appendix B).

Advocates and/or people with specific expertise may be consulted or involved as requested.

The planning process encompasses all aspects of the participant's life, including but not limited to home, school or work, leisure and recreation, cultural and spiritual needs.

POLICY 8: The person-centred planning process shall identify the roles and responsibilities of those providing support to the participant in achieving her goals.

Considerations:

A key person is designated as the fixed point of responsibility to oversee this process and to co-ordinate the efforts of all.

POLICY 9: The person-centred plan shall be documented.

Considerations:

The participant's decisions, goals and supports required are written, including a start date, review date, target date and persons responsible to assist and/or provide support.

Reviews and updates will be documented.

The participant will decide who receives a copy of the documented plan in whole or in part.

If a comprehensive behaviour support plan is in place, it will be documented in the participant's person-centred plan.

COMPREHENSIVE BEHAVIOUR SUPPORT

This section addresses support strategies to modify or affect a participant's ongoing challenging behaviour or dangerous or harmful behaviours, the use of medication to affect behaviour, and documentation requirements.

Support Strategies for Ongoing Challenging Behaviours and/or Ongoing Dangerous or Harmful Behaviours

POLICY 10: Comprehensive Behaviour Support shall be used when designing support strategies to affect a participant's challenging behaviour, or dangerous or harmful behaviour.

Considerations:

Comprehensive Behaviour Support is a support strategy that addresses four components:

- Ecological changes
- Positive programming
- Focused support
- Reactive strategies

Comprehensive Behaviour Support is described in detail in Appendix D.

The objective of Comprehensive Behaviour Support is to facilitate lifestyle changes rather than solely reducing the frequency, duration or intensity of challenging behaviours. Support strategies may be considered successful when the participant is able to engage meaningfully in a variety of home, school, community and work settings (where she may have been previously excluded due to the challenging behaviour), and when relationships are nurturing, caring and reciprocal.

Strategies addressing the components of Comprehensive Behaviour Support are based upon thorough objective assessment of the factors influencing a participant's behaviour (refer to Policy 11).

The Core Group is responsible to ensure that:

- A Comprehensive Behaviour Support plan is developed,
- Time lines are set for the development and implementation of the Comprehensive Behaviour Support plan, and
- An individual with expertise in Comprehensive Behaviour Support is involved in the development of the Comprehensive Behaviour Support Plan.

Strategies are developed and implemented in the spirit of collaboration, not control or coercion.

The participant's preferences, decisions, input and suggestions are respected and incorporated into the Comprehensive Behaviour Support plan through the Supported Decision-making process (see Appendix B). The participant is involved through discussion, observation, and assessment.

POLICY 11: Comprehensive Behaviour Support strategies shall be based upon the analysis of objective and thorough assessment information.

Considerations:

There are three general assessment categories:

- Lifestyle preferences
- Clinical issues
- Functional analysis

The nature, order and use of the assessment methods contained in these three categories are addressed in Appendix E.

Assessment methods must be objective. Objectivity is improved when information is gathered by observing behaviour rather than relying upon subjective opinions or feelings.

The assessment process requires a team approach involving the participant, the core group, other individuals who know the participant well, an individual with expertise in behaviour analysis, and in some circumstances professionals with specific clinical knowledge, (e.g., medical doctor, psychologist). The core group, including an individual with expertise in behavioural analysis, will decide which assessment methods are used as well as the order in which they are used.

An individual skilled in behavioural analysis will analyse assessment information in order to develop a hypothesis that explains the occurrence of the challenging behaviour. The quality of the assessment information obtained and the expertise of those who analyse the information influence the accuracy of any hypothesis. This hypothesis leads to the development of appropriate support strategies.

POLICY 12: Comprehensive Behaviour Support strategies shall be documented in a Comprehensive Behaviour Support Plan.

Considerations:

The Comprehensive Behaviour Support Plan shall include:

- A description of the assessment process and the assessment results (see Appendix E)
- A record of the process used with the participant to determine her preferences, decisions, input and suggestions (refer to Appendix B.)
- A description of the Comprehensive Behaviour Support plan that includes the strategies to be used in each of the four components: ecological changes, positive programming, focused support and reactive strategies
- The date, the names of those who drafted the document, and the locations in which the Comprehensive Behaviour Support plan is used
- Plans for the documentation of the occurrence of ongoing challenging and/or ongoing dangerous or harmful behaviours
- Plans for ongoing evaluation of the strategy
- Plans for withdrawing the strategy
- Results of the strategy

Documentation will be stored and maintained in ways that respect the participant's privacy and dignity.

USE OF MEDICATION TO AFFECT BEHAVIOUR

POLICY 13: The use of medication intended to affect challenging behaviour is a component of, not a substitute for, Comprehensive Behaviour Support and shall be carefully planned and strictly monitored.

Considerations:

This policy also applies when medication is prescribed by a physician for a psychiatric disorder.

Use of the medication is guided by a protocol that is outlined in Appendix G. The protocol acts as a safeguard against ineffective or unnecessary treatment, potential health risks, and harmful side effects.

DANGEROUS OR HARMFUL BEHAVIOURS THAT HAVE NOT OCCURRED BEFORE

POLICY 14: Service providers shall have an established policy for addressing participants' new behaviours that are dangerous or harmful to self, others or animals.

Considerations:

The policy will focus on prevention and contain specific methods for preventing the occurrence of the dangerous or harmful behaviour. Appendix D describes appropriate responses to dangerous or harmful behaviours.

Responses must not include mechanical restraint.

Upon the occurrence of a new dangerous or harmful behaviour the core group will determine whether a Comprehensive Behaviour Support plan needs to be developed in order to prevent future occurrences of the behaviour.

Appendix H contains guidelines for the development of a policy for addressing participants' new behaviours that are dangerous or harmful to self, others or animals.

Policies established by service providers will be compatible with the policies in this document.

POLICY 15: Dangerous or harmful behaviours that have not occurred before shall be documented.

Considerations:

The purpose of documentation is to aid in the development of a Comprehensive Behaviour Support Plan.

Appendix H contains documentation guidelines.

APPENDIX A: LEGISLATION

CANADIAN CHARTER OF RIGHTS AND FREEDOMS

A copy of the *Canadian Charter of Rights and Freedoms* is available from your local Member of Parliament office.

The Canadian Charter provides the protection under the following categories:

- Fundamental freedoms
- Democratic rights
- The right to live and seek employment anywhere in Canada
- Legal rights
- Equality rights for all individuals
- Official languages of Canada
- Minority language education rights
- Native people's rights

Some of the rights and freedoms in the Charter include:

- Freedom of conscience and religion
- Freedom of thought, belief, opinion and expression
- Freedom of peaceful assembly
- Freedom of association
- The right to vote
- The right not to be subjected to any cruel or unusual punishment
- The right to the equal protection and equal benefit of the law without discrimination

SASKATCHEWAN HUMAN RIGHTS CODE

A copy of the *Saskatchewan Human Rights Code* is available from the Saskatchewan Human Rights Commission.

An objective of the Code is "to further public policy in Saskatchewan that every person is free and equal in dignity and rights and to discourage and eliminate discrimination."

The Code includes the Bill of Rights and the Prohibition of Discriminatory Practices. The Bill of Rights includes:

- The right to freedom of conscience
- The right to free expression
- The right to free association

- The right to freedom from arbitrary imprisonment
- The right to elections
- The right to engage in occupations

The Prohibitions of Discriminatory Practices include:

- Discrimination in the purchase of property
- Discrimination in occupancy of housing accommodation
- Discrimination in places to which public is admitted
- Discrimination in education
- Discrimination in employment

UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD

A copy of the *United Nations Convention on the Rights of the Child* is available from the Children's Advocate.

This Convention states "State Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind. In all actions concerning children, the best interests of the child shall be a primary consideration."

In addition to the rights outlined for all children, the Convention has made additional provisions under Article 23 for children with disabilities. These provisions include:

- Recognition that a mentally or physically disabled child should enjoy a full and decent life in conditions which ensure dignity, promote self reliance and facilitate the child's active participation in the community

- Recognition of the right of the disabled child to special care based on the child's condition, the circumstances of the parents or others caring for the child and the available resources

- Recognising the special needs of a disabled child, assistance shall be designed to ensure that the child has effective access to and receives education, training, health care, rehabilitation services, preparation for employment and recreation opportunities to achieve the fullest possible social integration and individual development

APPENDIX B: SUPPORTED DECISION-MAKING[1]

BACKGROUND

Supported Decision-making is about respecting the fundamental right of all Canadians to be self-determinant. The right to make decisions is stipulated in the Canadian Charter of Rights and Freedoms in Section 2 and Section 15 and applies to all Canadians.

Traditionally, people with disabilities have been provided with few opportunities to be self-determining. They have been receivers rather than determiners of services. From this traditional perspective, people with disabilities have been viewed as being incompetent because of the nature of their disability. Because Supported Decision-making is built from the perspective of the Canadian Charter of Rights and Freedoms, it supports the notion that all people are competent and that we must work towards ensuring that the ways we support people are also competent.

THE SUPPORTED DECISION-MAKING FRAMEWORK

Based on the Canadian Charter of Rights and Freedoms, the framework for Supported Decision-making consists of three components:

PRINCIPLES

Principles are the context from which we support people to make decisions. These principles are "nonnegotiable" and encompass and extend those stated in the Canadian Charter of Rights and Freedoms.

1. All humans have a "will." The human will is the inner drive to choose or determine how you live.

2. Each person has the right to self-determination: the right to make decisions.

3. We have a duty to respect the decisions that other people make and help them achieve their dreams.

4. Decision-making is a fundamental human right. It is guaranteed in the Canadian Charter of Rights and Freedoms and in Canadian and provincial/territorial human rights laws.

5. A person's right to make decision is not limited or removed by disability.

6. The right to make decisions includes the right to have the support needed to make decisions and to let others know about them.

7. In Supported Decision-making, the individual is the centre of the decision-making process.

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1. With the permission of the author's, this information is summarised from Supported Decision Making Workbook (Bodnar & Coflin, 2001; see also Appendix I: Reference Materials)

RELATIONSHIPS

Making decisions is based upon the relationships we have with others, i.e., those who are important to us, who help us, and most importantly, and those whom we trust. Supported decision-making reflects the concept of interdependence in relationships rather than dependence. Therefore, it recognises that decision-making is something we do with the help and support of others. It is something that we do not do alone. Relationships can be viewed from two perspectives:

The participant - this perspective refers to how the person provides information about themselves to their supporters, including their personal history, their skills and abilities, likes and dislikes and goals and dreams.

The supporters - this perspective refers to those who support someone to make decisions. It may mean collecting information, determining options, interpreting decisions and providing advice and consultation. It does not necessarily mean that advice will be followed. The perspective of the supporter must be to respect the values of the participant, respect the right of that participant to make decisions and to dream, plan and work toward the empowerment of the participant.

THE DECISION-MAKING PROCESS

Based on the Principles and Relationships, decision-making follows a generic process that we all use:

1. Determine what decision needs to be made. What does the person want?
2. List the possible options. There is usually more than one way of getting what the person wants.
3. Get any information needed to make the decision.
4. Consider the pros and cons of each choice.
5. Make a decision.
6. Look at what happened. Is it what the person wanted? If not, why not?
7. What is the next decision? Begin the process again.

The participant and the supporters together decide what the process will look like, including what decisions require support, how the team is called together, what to do when emergency decisions are required, how disagreements will be handled and what decisions must involve other people.

Supported Decision-making is a process of supporting people with disabilities to be self-determining - of ensuring that their rights are respected. It empowers people to assume their citizenship rights and respects their right to dream, plan and be heard. To be effective, supported decision-making requires a foundation of the right people, trust amongst all involved and a strong commitment to the principles, values and process.

APPENDIX C: PLANNING PROTOCOL FOR MOVING TO A DIFFERENT HOME

PURPOSE

The purpose of this protocol is to establish a systematic planning process for all participants moving to a different home. Within the protocol all the activities necessary to support the participant's successful transition to another living arrangement are identified, co-ordinated and implemented. The participant is the central focus of planning and her participation is critical. The processes outlined in this document are based on the principles of Person Centred Planning and supported decision-making. The planning guidelines that follow are designed to facilitate, not hinder the realisation of a meaningful life for the participant.

OVERVIEW

The planning protocol establishes standards for effective planning with participants. It outlines the tasks and issues critical to a successful move, provides a protocol for addressing these in a systematic and co-ordinated fashion and identifies roles and responsibilities of the various key players.

APPLICATION

The planning process is to be implemented whenever a participant is moving to a different home. The process is initiated whenever there is a request or a need for a new service or change in existing service. The process described below applies to any type of residential move.

It is the responsibility of each core group member involved in planning to be familiar with the protocol outlined in this document and to assume the responsibilities that pertain to him or her.

GENERAL PLANNING PROCESSES

1. Initiation of Planning
2. Initial Meeting
3. Notice of First Planning Meeting
4. Development of a Support Profile
5. Implementation
6. Transition
7. Follow-up

1. Initiation of Planning

Planning is initiated when there is a request or a need for a change in the current home or a request for a different home. The participant, family members, present service providers or Community Services Workers may make a request or identify the need for a change in service. The participant's Community Service Worker will be made aware of the request or need, and is responsible to organise the initial meeting. It is the responsibility of the Community Service Worker to assemble at the initial meeting, those individuals currently involved in providing supports to the participant.

2. Initial Meeting

The group of individuals assembled for the initial meeting is responsible to:

a. Identify an Appropriate Person to Help the Participant Prepare for her First Planning Meeting

Prior to the scheduling the first planning meeting, the identified person will meet with the participant to discuss the planning and to determine the participant's wishes. An appropriate level of support must be provided so that the participant has the opportunity to discuss her wishes and other matters, including:

- The purpose of the first planning meeting and what will take place
- Who the participant wants to include as members of her core group and who will participate in the planning process
- What she would like to have discussed at the first planning meeting
- Where the participant would like the first planning meeting to take place

b. Identify Members of the Core Group

The core group will engage in the planning process and function as a planning team to arrange appropriate supports for the participant. The core group consists of those identified below, unless the participant has objected to their participation:

- The participant
- Family member(s)
- Those requested by the participant
- Community Living Division Community Service Worker
- Those providing program support currently or in the future, where appropriate
- Current primary service providers (as appropriate)
- Future service provider (if known and as appropriate)
- Others with specific expertise as requested by core group members

c. Identify Information Required for the First Planning Meeting

The group will determine relevant information required for planning, and will determine responsibilities and timelines for compilation, collection and distribution of planning information. Those preparing reports and sharing information will ensure that the participant (or her guardian) has agreed to the sharing of each of these reports. If the participant refuses, the reports are not shared. Relevant information will include:

- A description of the participant's functional abilities, quality-of-life activities, daily routines, current Person-centred Plan and her Comprehensive Behaviour Support Plan, as appropriate
- A report describing family involvement, if the family will not be present at the initial planning meeting

If the participant has a history of challenging behaviours a report will be prepared following the guidelines for Confidential Client Information Reports (CCIR). The CCIR guidelines can be obtained from a Community Living Division Program Development Consultant or Valley View Centre Behaviour Therapy Co-ordinator.

d. Identify Key Person

The Key Person is the fixed point of responsibility that oversees the planning process, co-ordinates the efforts of all, and ensures that all actions are carried out as agreed upon by the team. Any member of the core group (see #2b.) can fill the role of the Key Person, and the Key Person may change, when appropriate, throughout the planning process.

At this initial meeting a Key Person is identified to ensure the planning processes identified above are completed following the timelines agreed by the core group. This person is also responsible to co-ordinate the first planning meeting.

3. Notice of First Planning Meeting

The Key Person is responsible to ensure that core group members identified at the initial meeting are informed of; the initiation of planning, the date for the first planning meeting and any responsibilities that have been assigned to them, with the appropriate timelines. At this time, core group members will be requested to identify other people with specific expertise (e.g., psychiatrist, community physician) who should be invited to the first planning meeting.

At the first planning meeting, the Key Person will ensure that the following items are included on the agenda:

- Explanation of the process of comprehensive planning
- Explanation of the role of the Key Person
- Discussion of the principles of effective planning
- Clarification of any information contained in the reports distributed prior to the meeting

4. Development of a Support Profile

The development of a support profile is initiated at the first planning meeting. Discussion during this meeting and all subsequent meetings will be conducted in a manner that centres on the participant and is respectful of her wishes and dignity. The objective of planning is to determine the participant's vision of a meaningful life, program support requirements and appropriate financial arrangements. The following items provide a useful guideline for identifying and co-ordinating supports necessary to ensure the participant's successful transition to her new home setting.

a. Participant's Vision of a Meaningful Life

One of the first steps in planning is determining what the participant sees as a meaningful life (e.g., where or with whom the participant wants to live, how she would like to spend her leisure time and how she might wish to be involved in community life).

If the participant is unable to talk about her vision, the members of the planning team who know the participant well may assist in identifying the kinds of people, experiences, and activities to which the participant reacts positively or negatively. This process may help to create a picture of the opportunities that would contribute to a satisfying lifestyle for the participant. A strategy needs to be established that provides the participant with opportunities to engage in a broad range of life experiences. Her reactions to such experiences may be helpful in the modification of plans in the future.

b. Program Supports

Program supports that enable the participant to live a meaningful lifestyle are identified. Such program supports may include:

- Providing an appropriate living arrangement that accommodates a participant's level of independence, required supports, preference for roommates, need for respite, etc.
- Determining what the participant's typical day might look like
- Making community connections and maintaining ongoing personal relationships
- Identifying what medical supports are required (including the administration of medications, specialised procedures and follow-up)
- Providing specialised equipment
- Accessing required behavioural supports
- Accessing required mental health supports
- Providing other opportunities required to assist the participant in realising her vision

c. Financial Arrangements

Financial arrangements are identified, including any new funding sources required:

- INAC (Indian and Northern Affairs Canada)
- OAS (Old Age Security)
- SAP (Saskatchewan Assistance Plan)
- EI (Employment Insurance)
- EAPD (Employment Assistance for Persons with Disabilities)
- GIS (Guaranteed Income Supplement)
- Worker's Compensation
- Canada Pension Plan
- Self
- Trusteeship

Financial arrangements are identified for associated costs:

- Transportation
- Special needs
- Transition

5. Implementation

Upon consideration of the participant's vision of a meaningful life and supports required, a decision will be made regarding:

- Whether the existing resource can be modified to meet the participant's needs and preferences
- Whether applications will be made to existing community services which meet the participant's needs and reflect her preferences (these are to be specified with options if any)
- Whether a new resource needs to be developed to meet the participant's needs and preferences (the person responsible for exploring the development of such resources will be identified at the planning meeting)

If a move is required the Key Person will identify actions, assign tasks and ensure that those tasks are carried out. The required actions include:

- Establishing liaison with the Community Service Worker in the district where applications are being made or where resource development is being explored
- Completing and submitting application forms along with necessary supplementary reports and information
- Presenting application information an agency Admission Committee meeting by appropriate core group members

- Updating the planning team on the status of applications/resource development
- Determining medical supports and resources required to meet needs, including consent for medical procedures
- Informing or updating the PDC who may become involved
- Determining behavioural supports:
    - Strategies to be implemented prior to move, with responsibility assigned.
    - Assessment of the need for the development of a comprehensive behavioural support plan
    - Initial follow-up by current program support person or immediate transfer to another community resource person.

Throughout the planning process, the Key Person is responsible for ensuring that the participant's vision for a meaningful life is being fulfilled.

6. Transition

When the participant moves to an existing resource or a new resource the core group will identify the transition process that would best meet the needs of the participant. The core group will also identify who is responsible for carrying out each of the various tasks. The following issues will be addressed:

- Whether visits to her current home by people supporting the participant in her new home are necessary, and who is responsible for co-ordinating the visits
- What support the current service provider may provide after the participant moves to her new home and how this will happen
- What the process will be to provide necessary information about the participant and her required supports to the new service provider
- What the process will be to help the participant become familiar with her new home
- How the participant will be prepared for leaving her current home (including when and who is responsible for the details of the arrangements)
- What special equipment is required
- What medications are required
- How clothing and personal items are arranged for both during visits and the eventual move

- What behavioural supports are required, including:
    - Strategies to be implemented prior to move, with responsibility assigned
    - Assessment of the need for the development of a comprehensive behavioural support plan
    - Initial follow-up by current program support person or immediate transfer to another community resource person
    - Referral for PDC services, if not already in place, and if deemed to be required.

7. Follow-up

Once the participant has moved to her new home a Person-centred Planning meeting will be convened within 6 weeks. The Person-centred Plan will reflect the participant's needs and desires in her new environment. The Key Person co-ordinates this meeting. The core group members will change once a move has occurred. The core group will consist of those identified below, unless the participant has objected to their involvement:

- Participant
- Family member(s)
- Those requested by the participant
- Key Person
- Community Living Division Community Service Worker
- Program support person
- Primary service provider
- Others with specific expertise as requested by core group members

The role of Key Person is transferred at the first Person-centred Planning meeting in her home. The new Key Person is identified by the participant and her core group and becomes the fixed point of responsibility for future planning and co-ordination of supports. Transfer arrangements include:

- Forwarding to the Community Living Division Community Service Worker the participant's Community Living Division file containing current chronological recordings, program information, correspondence, medical information, assessments, social history, Person-centred Plans, applications, etc.
- Transfer of program support

APPENDIX D: COMPREHENSIVE BEHAVIOUR SUPPORT

The objective of Comprehensive Behaviour Support is to facilitate meaningful lifestyle changes rather than to solely reduce the frequency, duration or intensity of challenging and/or dangerous or harmful behaviours. Although challenging and/or dangerous or harmful behaviours are regarded seriously, they are not the primary focus of the support strategy. One must look beyond the behaviour itself and focus upon teaching new behaviours and creating an environment where the participant feels accepted by, and important to, those who live and work with her. Support strategies may be considered successful when the participant is able to participate meaningfully in a variety of home, school, community and work settings (where she may have been previously excluded due to the challenging behaviour) and when relationships are nurturing, caring and mutually gratifying. This array of outcomes is not likely to be produced by any one strategy; rather what is required is a Comprehensive Behaviour Support plan with multiple components.

To address the full range of outcome requirements, support plans may include strategies in each of the four components of Comprehensive Behaviour Support:

1. Ecological changes
2. Positive programming
3. Focused support
4. Reactive strategies

When designing a Comprehensive Behaviour Support plan, one considers the patterns and routines of the participant's daily life, her interactions with others, her preferences and her dislikes. Support strategies may be used to reduce stress, deprivation and fear, or to increase those things that enrich the participant's life, compliment other preferred activities, and engage her interest. An effective and ethical Comprehensive Behaviour Support plan assists the participant in building a meaningful life.

One may indirectly affect the occurrence of challenging and/or dangerous or harmful behaviours by making changes to the participant's environment (i.e. ***ecological changes***) or by teaching new adaptive skills through ***positive programming***. Because ecological changes and positive programming may take time to work, there are instances when the challenging and/or dangerous or harmful behaviour itself is targeted for change or reduction by using ***focused support*** strategies. When the challenging and/or dangerous or harmful behaviour presents imminent danger to the participant or others, ***reactive strategies*** may be needed to ensure safety.

Reactive strategies alone do not constitute a Comprehensive Behaviour Support Plan.

ECOLOGICAL CHANGES

Behaviours occur within a context and often are a function of a person's physical, interpersonal and programmatic environment. The events in and the characteristics of a participant's environment (i.e. the ecological context for behaviour) are important areas of analysis that provide information that may be used in developing a support plan. Ecological changes attempt to smooth the fit between the person and her environment by modifying or enhancing the environment. Strategies that seek to modify or adapt the ecology of the participants are usually the most important part of a support plan.

Ecological change support strategies involve applying planned environmental changes that are expected to produce eventual changes in behaviour (e.g., changing the setting in which activities occur, changing the number and quality of interactions, changing the instructional methods being used, attempting to understand what the person is communicating through her behaviour, changing instructional goals, and removing or controlling environmental pollutants such as noise or crowding). The effectiveness of ecological change strategies is influenced by the quality of information obtained during the assessment process.

POSITIVE PROGRAMMING

Positive programming involves assisting the participant to develop new skills and competencies that will assist her in better coping with her environment. There are four common variations of *Positive Programming*:

1. Teaching a new behaviour or class of behaviours

   (E.g., a person who is introverted or withdrawn may benefit from learning assertiveness and social skills)

2. Substituting a more socially appropriate behaviour

   (E.g., replacing inappropriate touch with appropriate handshaking)

3. Assigning meaning to behaviour

   (E.g., for a person who typically begins lightly pounding the table prior to displaying dangerous or harmful behaviour and caregivers respond to the light pounding as communication that the person wishes a break from work)

4. Substituting a communicative means

   (E.g., it is quite common for a person's attempt at communication to be labelled as a dangerous or harmful behaviour, for example, throwing work supplies across the room may be described as dangerous or harmful behaviour, when that person may simply lack the communicative means to say "I don't know how to do this")

By developing new skills and competencies, the participant may be less reliant on challenging and/or dangerous or harmful behaviours as a means to cope with her environment. These new skills and competencies targeted for development may have little apparent relationship to the challenging and/or dangerous or harmful behaviours that may be occurring.

The methods commonly used to increase skills and competencies may include:

- Positive reinforcement
- Shaping
- Chaining
- Stimulus Control
- Modelling
- Verbal prompts or instructions
- Fading
- Physical prompts or assistance

For detailed information on the above methods, please refer to the publications noted in the Reference Materials section of this document (Appendix I).

FOCUSED SUPPORT

Ecological changes may take time to arrange. Positive programming may require some time before new skills and competencies are mastered. There also may be instances when ecological changes and positive programming strategies are unable to sufficiently modify (i.e., change or reduce) the occurrence of challenging and/or dangerous or harmful behaviours. In these circumstances it may be necessary to target the behaviour directly for change or reduction by the application of focused support strategies. The purposes of focused support strategies is to produce the most rapid effects possible, to reduce the risks associated with the behaviour, and to reduce the need for reactive strategies. The application of focused support must be preceded by a thorough analysis of the factors influencing the challenging and/or dangerous or harmful behaviour (refer to policy 12 and Appendix E).

Focused support strategies are commonly derived from behavioural theory. As with positive programming strategies, focused support is rooted in positive reinforcement. Strategies may include:

- Modelling or demonstrating desired, alternative or incompatible behaviours

- Positively reinforcing desired, alternative or incompatible behaviours (i.e., Differential Reinforcement)

- Modifying the antecedents (the set of circumstances immediately preceding the behaviour that may serve to cue the behaviour) to the behaviour

- Modifying the consequence (the set of circumstances immediately following the behaviour that may serve to reinforce or motivate the behaviour) of the behaviour

- Teaching the participant to monitor and manage her own behaviour (i.e., Self-Management or Self-Monitoring)

For detailed information on the above methods, please refer to the publications noted in the Reference Materials section of this document (Appendix I).

Focused support interventions may also involve methods outside behavioural theory that require other professional opinions such as counselling, medication adjustments and diet changes.

REACTIVE STRATEGIES[1]

Ecological changes, positive programming and focused support do not describe what to do when behaviour occurs; they are proactive, not reactive. Reactive strategies address episodes of dangerous or harmful challenging behaviour with the least amount of risk of injury to the participant, service providers and others in the environment. Reactive strategies do not produce changes in the future, but rather keep people safe in the here and now and/or reduce the harmful impact of the participant's behaviour. Reactive strategies may include active listening, stimulus change and crisis intervention

The following responses offer ways to manage dangerous or harmful behaviour that are positive, preventative, dignified and constructive. These guidelines describe a continuum of less to more involved or intrusive responses. It is not to be implied that because of the less to more restrictive order of presentation, this order must be followed in the case of an emergency involving potentially harmful behaviour. Rather, the responses should be used in such a way that is not more restrictive or intrusive than is necessary to prevent the participant from harming herself or others and that is applied no longer than necessary to prevent or contain the dangerous or harmful behaviour.

A. Positive Approaches

The first emphasis of responses designed to manage dangerous or harmful behaviour is to provide positive programming that develops the individual's communication, vocational, recreational, social, community and coping-skills. Within this context, we can take steps toward reducing dangerous or harmful behaviour. As a participant learns more effective daily living and coping-skills, dangerous or harmful behaviours tend to occur less often, if at all.

Positive programming teaches more effective and socially acceptable ways of getting one's needs met and of coping with the realities of the physical and interpersonal environments in which the person must act and interact. Positive programming teaches people how to have their needs met and cope with people and events in their life in the most acceptable manner.

Positive programming emphasises the importance of providing frequent positive feedback and constructive assistance. Attention is provided frequently in non-contingent social interactions, i.e., offering attention solely for the reason of giving individual attention. Frequent positive interactions among people are effective in preventing or lessening the frequency and intensity of many occurrences of dangerous or harmful behaviours.

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1. This information also appears in the *Violence and/or Abusive Behaviour Toward Workers Policy Guidelines* (pp R1-R11) and the *Approved Private Service Home Abuse Policy* (pp 10-22). It has been adapted from Willis, T., & LaVigna, G. (1985). Emergency Management Guidelines. Los Angeles, California: Institute for Applied Behavior Analysis.

B. Surface Management Responses for Dangerous or Harmful Behaviour

Surface management strategies are designed to influence behaviour until positive programming can have the opportunity to affect change. Surface management responses are short-term techniques.

Many dangerous or harmful behaviours are either cued by events or situations in the environment (i.e., antecedents) and/or occur in a typical or predictable behavioural chain. Surface management responses manipulate either the antecedent/precipitating events or interrupt the chain of the dangerous or harmful behaviour.

The first category of surface management strategies is eliminating precipitating events or antecedent control strategies; the second is interrupting the behavioural chain.

1. Eliminating Precipitating Events

   a) Remove seductive objects

      - Objects, events and materials in the environment can serve as cues for someone to act in a certain way, i.e., by removing seductive objects, dangerous or harmful behaviours are likely to be eliminated, or at least to be reduced in frequency

   b) Relocate people

      - Some people just don't get along with others; at the table they may touch, push, grab or pull at each other, or they may attack others as soon as they come in close proximity
      - By attempting to keep people in different locations, potentially dangerous situations may be avoided while in the mean time positive approaches are beginning to take effect

   c) Remove unnecessary demands and requests

      - People sometimes react with dangerous or harmful behaviour when they are presented with demands or are pursued for compliance; in these situations the removal or lessening of demands/requests is likely to reduce many potentially dangerous situations
      - When individuals do react to requests with dangerous or harmful behaviours, it is important to be sensitive to their emotional or physical state; under conditions where they are extremely upset or frustrated it may be advisable not to issue demands requiring compliance at that time
      - A person may also be sensitive to particular demands given in a particular way; it would therefore be advisable to temporarily eliminate the request, and to find a better way to approach the person
      - It may also be possible the person does not understand the request or that they are afraid of doing the task incorrectly because it is too difficult

- If you find an effective way of making requests of a person without upsetting them, share that approach with others
- Generally the word “no” is a cue for anxiety or anger in many of us; offer the participant a choice of alternative activities, suggest a different course of action or rephrase your response eliminating the anxiety inducing words

d) Change the location and time of activities

- Certain people may exhibit dangerous or harmful behaviours reliably in certain situations and at select times, e.g., hitting may occur only in the dining room, tantrums may occur only at shift changes but not at any other time; by changing the location or time of activities the dangerous or harmful behaviours may not present themselves, e.g., with a person who assaults others when she is awakened abruptly, try letting her wake up in a more gradual way to prevent the assaults

e) Rearrange the environment

- Some dangerous or harmful behaviours are tied to specific arrangements of furniture in select situations, e.g., a person may hit others only when she sits in a specific chair that is pointed in a specific direction; by changing the chair and her position, it is possible to eliminate the dangerous or harmful behaviour

f) Eliminate events that cue the behaviour

- If you have identified a stable relationship between the occurrence of an event and the occurrence of the dangerous or harmful behaviour, eliminate the event

2. Interrupting the behavioural chain

Some dangerous or harmful behaviours are frequently part of a chain or a sequence of events that progresses from less to more severe, e.g., hitting others may begin with verbal protests and crying. It may be possible to prevent dangerous or harmful behaviour by eliminating the early events in the behavioural chain.

a) Facilitating communication

- Efforts to help people communicate effectively may reduce the likelihood that dangerous or harmful behaviours will appear
- When people begin to show signs of agitation or frustration, or when they show the early signs of escalating to more severe behaviours, every effort should be taken to determine their problem, to encourage to express themselves
- Specific questions might include: “what do you want”, “do you have a problem?” and “do you need help?”
- To assist individual’s to express themselves at the time, a combination of adapted communication, active listening, and best guessing techniques is useful
- Keep your language simple, the fewer words the better

b) Proximity control

- We might observe that someone is less likely, if at all, to display dangerous or harmful behaviour when a service provider is present or in close proximity; under such situations, simply moving closer to the person when they appear upset may be sufficient to prevent a full-blown episode
- Proximity control lets the person know that you are aware of what they are doing and that you are there physically to support them

c) Inject humour

- We may be able to prevent a problem from occurring or escalating by making a playful or humorous comment to a person who appears grim, sad, or agitated
- Following the use of injecting humour, it is important that the person have the opportunity to communicate what was bothering them and/or be given emotional support

d) Instructional control

- Often, people are willing to change their behaviour when given the instruction to do so; instructions can be used to divert a person to more appropriate activities or to stop ongoing activities, e.g., telling a person who is about to hit others or one's self "hands down", or telling a person who is agitated and escalating towards aggression to "leave the room", or to "help me move these pillows", or some other task to divert attention
- This technique is useful for someone who derives pleasure out of helping others

e) Facilitated relaxation

- If the person continues to be upset, agitated, self-abusive or destructive when other methods have been attempted, instructions to relax may be used to help the person learn the process of relaxing
- The process must be one of encouragement, not forced compliance

f) Stimulus change

- This strategy involves presentation of an unexpected event or alteration of stimulus conditions in an effort to temporarily manage a behaviour or stop it
- This method is useful when a person is in the process of attacking, when aggressive acts are imminent, when serious behaviour is occurring in an unending chain, e.g. turn up or down the volume of music, ask another participant to dance, giving a ridiculous instruction, going completely limp when being assaulted or dropping to the floor and playing dead
- Stimulus control techniques are only effective once or twice

C. Geographical Containment

Geographical containment involves the use of physical features in the immediate environment to prevent harm and to minimise or eliminate the consequences of dangerous or harmful behaviour. The purpose is to reduce or eliminate the need for physical contact with the person. Techniques include placing objects between you and the person exhibiting harmful or dangerous behaviour. Removing all others from the immediate environment and calling for help should protect the safety of others.

D. Evasion

Evasion includes a variety of techniques and manoeuvres that serve to deflect blows and kicks and generally staying out of harms way.

E. Emergency Physical Containment

Emergency physical containment involves non-demeaning physical contact between a service provider and a participant displaying dangerous or harmful behaviour. The physical contact involves only the minimally sufficient contact to briefly stop or prevent the participant or resident from causing serious injury or death to another person or herself. Emergency physical containment is not used to prevent or stop property damage. Emergency physical containment is used only when less intrusive methods (above) have been attempted but have not de-escalated the dangerous or harmful behaviour. Physical contact must not be painful for the participant, have the potential to injure or be used to punish. Physical contact must be brief as possible and be removed as soon as possible.

APPENDIX E: BEHAVIOURAL ASSESSMENT

A goal of assessment is to bring clarity and understanding to otherwise chaotic and confusing situations. We seldom reach this goal by focusing on a diagnostic label or the form of the behaviour. Assessment examines all aspects of the participant's life by addressing three main areas: lifestyle preferences, clinical issues and functional analysis.

Assessment precedes the development of a Comprehensive Behaviour Support plan. A comprehensive behavioural assessment process will determine the kind of life the participant wants to live, those things that are meaningful to her and the supports she needs to enjoy a meaningful life.

The assessment process requires a team approach involving the participant, the core group, other individuals who know the participant well, an individual with expertise in behaviour analysis, and in some circumstances professionals with specific clinical knowledge (e.g., medical doctor, psychologist).

The assessment process begins with determining the lifestyle the participant wants to live. Often, constructing a meaningful lifestyle results in the development of environments where the challenging behaviour is reduced or accommodated. Assessment of lifestyle preferences often yields the information required to design a Comprehensive Behaviour Support plan. In those instances where the challenging behaviour continues to interfere with the individual's quality of life, assessment needs to expand to investigate clinical issues, as well as a more detailed functional analysis of the challenging behaviour.

The information from the comprehensive assessment is used to develop a system of support that melds medical, architectural, behavioural and educational variables to create effective environments.

The core group, including an individual with expertise in behavioural analysis, will decide which assessment methods are used as well as the order in which they are used (e.g., in some instances the assessment of lifestyle preferences alone is sufficient to develop a Comprehensive Behaviour Support Plan; in other circumstances the team may decide to assess lifestyle preferences and clinical issues and perform a functional analysis simultaneously).

Lifestyle preferences, clinical issues and functional analysis are described below.

Lifestyle Preferences

The assessment of lifestyle preferences determines how a participant wants to live her life. From this information, efforts are made to design physical spaces, activity routines, learning opportunities and social interactions in which the participant will succeed.

Information gathering is done through interviews with the participant, observation of the participant across different settings and personal interviews with the family members and direct service providers. Assessment leads to the development of a vision for the participant's future and the identification of critical features of effective support. Lifestyle preference assessment determines the things that work for the participant and the things that should be avoided.

When determining the critical features of support, one will examine the following:

- Physical features of the living setting
- Living alone or with others
- Physical location of the home
- Nature of staffing support required
- Activity routines and patterns
- Degree of community participation and social networks
- Sleeping and eating routines
- Strong preferences and dislikes of the participant
- Instructional and behavioural strategies likely to be effective (or not effective)

Clinical Issues

Clinical assessment investigates the possible influence of neurological, medical or psychiatric variables on the challenging behaviour. Typically this type of assessment requires consultation with professionals who have expertise in these areas.

Examples of issues that may be detected or explained by clinical assessment:

- Cognitive processing difficulties
- Brain injury
- Learning disabilities
- Illness
- Ongoing medical conditions
- Acute psychiatric conditions (e.g., reactive depression)
- Chronic psychiatric conditions (e.g., schizophrenia)
- Sensory or communication pathology (e.g., hearing or sight disabilities)

Functional Analysis

Functional analysis involves the systematic assessment of the variables that set the occasion for the occurrence or non-occurrence of challenging behaviours and the consequences that maintain those behaviours. This assessment defines the events in the environment that reliably predict and maintain challenging behaviours. Behaviour is assessed through interviews, rating scales, direct observations, and systematic, experimental analysis of situations.

A thorough functional analysis includes a determination of:

- The possible influence of psychiatric, neurological, medical or other organic factors on the challenging behaviour (done through consultation with professionals)
- The antecedent conditions that may cue the behaviour
- The consequent conditions that may reinforce or reward the behaviour
- The elements in the environment or ecology that may be linked to the behaviour
- The frequency, duration and intensity of the behaviour
- The history of this challenging behaviour in the participant's life

Documentation of Assessment Information

Upon completion of behavioural assessment, the information gathered will be documented. The following items should be addressed in the documentation of the assessment:

1. **Description of the challenging behaviour**

   Clearly describe in objective terms the challenging behaviour being addressed.

2. **Assessment process**

   Briefly describe how information was collected, e.g., through interviews, file searches, observation, and formal assessment tools.

3. **Record of the information/data collected**

   In summary form, document the information obtained with each assessment method.

4. **Analysis of data collected**

   In summary form discuss any patterns or trends that emerged through analysis of the data. Discuss any conclusions discovered regarding the meaning or function of the presenting behaviour of concern. A hypothesis that explains the occurrence of the challenging behaviour should be developed (refer to policy 10).

5. **Further information required**

   If the assessment information gathered was insufficient in order to explain the occurrence of the challenging behaviour, further assessment may be recommended.

APPENDIX F: ABUSE

SECTION I: ABUSE POLICIES, PROTOCOLS & PROCEDURES

The following policies, with the exception of the *Provincial Child Abuse Protocol*, were developed through collaborative processes involving Community Living Division, Saskatchewan Community Resources and Employment, Saskatchewan Association of Rehabilitation Centres, Saskatchewan Association for Community Living, Early Childhood Intervention Program Saskatchewan Incorporated, and Saskatchewan Approved Private Homes Incorporated.

1. Community Living Division's ***Policy/Protocol for the Investigation of Abuse and Neglect Involving Adults with Mental Disabilities*** (October, 1995)

   This policy applies to all staff of Community Living Division and is to be followed when there are allegations of abuse/neglect involving adults with intellectual disabilities.

2. ***The Participant Abuse Policy*** (October, 1995)

   This policy applies to all staff, Board members, and volunteers of Community-Based Organisations funded by Saskatchewan Community Resources and Employment that provide services to individuals with intellectual disabilities. The abuse policy is to be followed when there are allegations of abuse or neglect involving individuals with intellectual disabilities who receive services from the organisation.

3. ***Approved Private Service Home Program Abuse Policy*** (May, 1999)

   This policy applies to all Approved Private Service Home operators who are licensed by Community Living Division under *The Residential Services Act*. It is to be followed when there are allegations of abuse or neglect of individuals residing in approved homes.

4. ***The Provincial Child Abuse Protocol*** (December, 1990)

   This protocol is part of *The Child and Family Services Act* passed by the Saskatchewan Legislature in 1989 (proclaimed on December 1st, 1990). Community Living Division staff, Early Childhood Intervention Program staff and Approved Private Service Home proprietors will follow this protocol when allegations of abuse or neglect of a child under the age of 16 years occur.

Other avenues for information on abuse include:

- *The Occupational Health and Safety Act* and Regulations.
- Saskatchewan Human Rights Commission
- Office of the Children's Advocate
- Provincial Ombudsman
- Saskatchewan Association for Community Living

SECTION II: PROHIBITED ACTIONS

The following actions are prohibited because they infringe upon the participant's basic human rights and dignity:

1. Abuse[1]

Physical Abuse:	inflicting bodily pain by one or more instances of striking, shoving, slapping, pinching, choking or kicking
Sexual Abuse:	any form of unwanted or exploitative sexual behaviour including harassment or acts of assault.
Emotional Abuse:	inflicting emotional pain through verbal or written expressions of intimidation, humiliation, ridicule, contempt or hatred (Includes yelling, swearing or screaming at others)
Property Abuse:	misusing a participant's funds or assets without consent, including unauthorised use of bank accounts or denial of personal possessions
Medication Abuse:	non-compliance with policies and procedures relating to medication administration, including withholding medication or over-medication, inappropriate use of medication, or failure to facilitate access to health services
Denial of Opportunity:	unreasonable denial of opportunity for economic advancement or intentional withholding of access to available opportunity to meet needs for spiritual, mental or personal growth and satisfaction
Neglect:	failure to provide the necessary care, assistance, guidance or attention which results in physical or emotional harm or loss to the adult or their estate (May be caused by an action or a failure to act, and may or may not be intentional)

2. Pain and Deprivation:

Psysical Pain:	stimuli or activities that may result in physical pain include but are not limited to ammonia spray, electric shock, water spray to the face, pinches and deep muscle squeezes
Psychological Pain:	stimuli or activities that may result in psychological pain include but are not limited to verbal abuse, including the ongoing use of stigmatising language, and outwardly aggressive interactions, including tone of voice and body posture
Deprivation:	stimuli or activities that may result in deprivation include but are not limited to withholding, withdrawing, or delaying visitation or private communication with family and friends, adequate sleep, shelter, bedding, bathroom facilities and food or drink or prolonged periods of isolation and seclusion

1. These definitions of abuse are found in the abuse policies of organizations funded through Community Living Division.

3. Withholding of Basic Rights

This category includes any action that interferes with a participant's basic rights, as listed below (some of these examples might meet the criteria for neglect or denial of opportunity, and would therefore be considered abuse):

- The right to be treated with dignity and respect
- The right to protection against exploitation and demeaning treatment
- The right to practice her religion
- The right to a personal living area including private bed, bedding and space for personal property
- The right to a nutritionally sound diet, balanced over each 24 hour period and available during at least three eating periods which are spaced throughout the normal waking hours (N.B., withholding of food as a behaviour intervention strategy is prohibited; this prohibition does not imply that individuals should in any way be forced to consume meals which have been offered and refused)
- The opportunity to spend time out of doors each week
- Access to water and bathroom facilities at frequent intervals
- Opportunity and free time to meet with staff, visitors, friends, relatives, advocate, etc. in private, including telephone conversations and letter writing
- The right to reasonable use of personal possessions such as tobacco, cigarettes, toys, books, radios, toiletries, mail and jewellery and the right to control access to those possessions
- Access to an adequate allowance of neat, clean and seasonable clothing from which the participant may select items appropriate to the activities she may be engaged in
- Optimal independence in health, hygiene and grooming practices
- The right to possess, control and access legitimate earnings and allowances
- Access to normal environmental and social contacts
- The right not to experience prolonged withholding of necessary treatment programs as a consequence of behaviour (including removal from or withdrawn opportunity to attend day programs, speech therapy, occupational therapy, physiotherapy, recreation, etc.)

4. Aversive Procedures

Aversive procedures are those stimuli or activities that are applied in response to a participant's behaviour that she perceives as physically or psychologically painful or harmful.

Any response by a service provider to a participant's behaviour has the potential of being experienced by the participant as aversive, even interventions generally considered positive. A determination needs to be made regarding whether the participant sees any procedure or event as aversive. This determination can be made by assessing the individual's reaction to the procedure or event.

APPENDIX G: Medication Protocol

When medication is considered/prescribed as a behavioural support, a medication protocol incorporates the following guidelines:

1. Prior to a decision to pursue the use of medication to address behavioural issues:
    - All effort is made to rule out possible medical causes of the behaviour
    - The core group shall evaluate the appropriateness and effectiveness of all positive strategies which have been implemented

2. The decision to pursue the use of medication as a behavioural support is made by the participant and their core group.

3. The core group will identify a key person who will contact the physician and who will support the participant during all medical interviews, appointments and/or assessments.

4. The core group will ensure that a baseline of the challenging behaviours has been completed. The baseline includes but is not limited to:
    - Description of the behaviour
    - The antecedents leading to the behaviour
    - The frequency, duration and locations of occurrences of the behaviour
    - The consequences of the behaviour and follow-up
    - A comprehensive analysis of antecedents, consequences and relevant ecological or environmental events

5. The key person will ensure that a comprehensive report containing all relevant behavioural information is submitted to the physician at least one week prior to the individual's initial appointment. Relevant behavioural information includes:
    - Baseline information
    - History of behavioural pattern and interventions to date
    - Reports of any formal behavioural and/or psychological assessment (e.g., Motivation assessment scale, needs analysis, communication functions of behaviour, Reiss screen)

6. Upon receipt of a prescription for the use of the medication to affect challenging, dangerous or harmful behaviour, the key person will ensure that the following information is obtained from the physician or pharmacist:
    - What specific behavioural changes will be observed as a result of taking this medication
    - How quickly will changes be evident, i.e. days, weeks, months
    - How much change in the behaviour can be expected
    - If anticipated changes in behaviour do not occur, what steps should be taken
    - How frequently will the medication be reviewed and what information will the physician need to adequately assess the effectiveness of the medication
    - If adverse effects or drug reactions occur, what steps should staff take and how should these be documented
    - Does the medication interact with certain foods? If so, which foods and what dietary precautions should be taken
    - Can the medication safely be crushed if the participant has trouble swallowing
    - Should the medication be taken with or without food
    - What time(s) of day should the medication be taken
    - What procedure should be followed if a dose of the medication is missed
    - When the behaviour has decreased significantly and is stable, what steps can be taken to decrease the dosage of the medication

7. The key person shall ensure that the participant is informed of the effects and side effects of all prescribed medications.

8. The core group will ensure that all relevant, appropriate, positive strategies continue to be implemented during the entire period that the participant requires medication as a behavioural support.

9. The core group will evaluate the appropriateness and effectiveness of all positive strategies implemented during the period that the participant requires medication as a behavioural support.

10. The key person will ensure ongoing documentation and review of all medications and necessary changes (i.e., Dosage, type, time, etc.) and incorporate this information into the individual's plan.

11. The key person will ensure that all Service Providers working with the participant are notified of the medication intervention and will provide the Service Provider with a written plan for safe and effective administration of the medication.

APPENDIX H: EMERGENCY RESPONSE POLICY GUIDELINES

There may be times when participants exhibit behaviours they have never exhibited before that present a danger to themselves and/or others. In an effort to protect these individuals and others around them, an emergency response policy offers guidelines of how to respond when these situations arise.

The Emergency Response Policy will:

- Provide direction to service providers according to the crisis cycle which is a model of escalation of behaviour
- Offer substantive approaches when a potential danger exists, presented in a hierarchy of increasing intrusiveness or restrictiveness, with the least intrusive/restrictive presented first (Least restrictive/intrusive is a procedure that is not more restrictive or intrusive than is necessary to prohibit the participant from inflicting harm to herself or others and applied no longer than necessary to prevent or contain the dangerous behaviour. Suggested responses to dangerous or harmful behaviours are outlined in Appendix D of this document.)
- Direct service providers not to approach a participant exhibiting dangerous/harmful behaviour alone, unless not to do so would put others at risk
- Direct service providers to remove others from the situation, if possible
- Outline techniques (calm, non threatening approach, reducing stimuli, stay out of individual's personal space)
- Direct service providers to protect herself and/or others if needed using the least restrictive response
- Direct service providers to report the participant's signs of escalating behaviour to the Supervisor and document information as soon as possible
- Direct service providers on when and how to access help within their organisation or from other community support services

The emergency response policy will address the reporting protocol service providers are required to follow. The documentation should contain, but not be limited to the following information:

- Name of the participant
- Date of the incident
- Time of the incident
- Place (location) of the incident
- The antecedents of the incident
- The reactive strategies and responses used by service providers (listed in order from the least intrusive to the most intrusive)
- An exact description of the action taken by service providers
- Witnesses to or others involved in the incident
- The outcome of the responses demonstrated by service providers
- The follow up plans (immediate and long-term)

The emergency response policy will address the requirement for service providers to develop a Comprehensive Behaviour Support plan with the participant (see Appendix D).

APPENDIX I: Reference Materials

Bambara, L. & Knoster, T. (1998). Innovations Designing Positive Behavior Support Plans. Washington, D.C.: AAMR.

This book is number 13 in the Innovations series published by the AAMR. Bambara and Knoster present positive and comprehensive behaviour support methodologies from definitions to practical case examples. This book is an excellent companion reference to the Comprehensive Personal Planning and Support Policy.

Bodnar, F., & Coflin, J. (2001). Supported Decision Making Workbook.

This manual presents supported decision-making as it applies to people with disabilities in Canada. Written in easily understood plain language, the manual provides a framework for both understanding and implementing Supported Decision-making. A Trainer's Guide is included with each of its five chapters.

Carr, E.G., Levin, L., McConnachie, G., Carlson, J.I., Kemp, D.C., & Smith, C.E. (1994) Communication-based intervention for problem behavior: A user guide for producing positive change. Baltimore, MD: Paul H. Brookes Publishing Co.

Carr et al. describe communication-based interventions for people with severe challenging behaviours. Their approach is designed to reduce challenging behaviour by teaching communication strategies. Challenging behaviour is viewed as having a function for the participant. Intervention focuses on education, not simply behaviour reduction. Lifestyle changes are presented as the ultimate goal of intervention.

Donnellan, A.M., LaVigna, G.W., Negri-Shoultz, N.N., & Fassbender, L.L. (1988). Progress without punishment: Effective approaches for learners with behavior problems. New York, NY: Teachers College Press.

This book presents a non-aversive technology in a practical format for service providers who work directly with individuals with serious behaviour challenges. It includes an overview of positive programming options as well as non-aversive behavioural and instructional techniques that lead to long-term behaviour change.

LaVigna, G.W., & Donnellan, A.M. (1986). Alternatives to punishment: Solving behavior problems with non-aversive strategies. New York, NY: Irvington Publishers, Inc.

This book provides comprehensive treatment alternatives to punishment in dealing with challenging behaviour. It describes effective non-aversive technology for supporting those with even the most severe behaviour challenges. Legal, administrative, ethical and procedural issues are presented. Also included are problem scenarios, support strategies, and research data.

Lovett, H. (1996). Learning to listen: Positive approaches with difficult behavior. Baltimore, MD: Paul H. Brookes Publishing Co.

This book presents a positive framework for understanding behaviour. Lovett encourages the reader to move from rehabilitation to accommodation, and from control to collaboration. He discusses the importance of listening empathetically and trusting the power of relationships.

O'Neil, R.E., Horner, R.H., Albin, R.W., Sprague, J.R., Storey, K., & Newton, J.S. (1997). Functional assessment and program development for problem behavior: A practical handbook. Pacific Grove, California: Brooks/Cole Publishing Co.

This handbook presents approaches for analysing challenging behaviours and developing support strategies. Their approach is rooted in the believe that effective behavioural support should not only reduce challenging behaviours, but should increase the opportunities for learning new skills, social inclusion, access to meaningful activities, and participation in their community. Examples of forms and procedures that have proven useful in school, work and home settings are included.

Reid, D. & Parsons, M. (2003). Positive Behavior Support Training Curriculum. Washington, D.C.: AAMR.

Dennis Reid and Marsha Parsons present a positive behaviour support curriculum for supervisors and direct staff. This comprehensive curriculum contains 15 modules in the direct support edition and an additional 10 modules in the supervisory edition. Some of the topics include dignity, defining behaviour, functional skills, role of environment, program implementation, role of choice, data analysis, and staff performance analysis.

Willis, T. & LaVigna, G. (1999). Emergency Management and Reactive Strategies Within a Nonaversive Framework. Los Angeles, Ca.: IABA.

Pioneers in the field of non-aversive behavioural support, Thom Willis and Gary LaVigna present non-aversive emergency management strategies in a lecture format over a series of 8 videotapes. This state of the art package includes a manual, study guide and references.