TITLE: Discipline and Behavioral Intervention

Policy Number: SD-BS-002

STATEMENT OF PURPOSE:

To establish an environment that provides opportunities and boundaries to promote a child's safety, health, growth, and development. To ensure Foster Caregivers and staff have a clear understanding, and the knowledge and skill to use discipline and behavioral interventions that are acceptable, and to know those which will not be tolerated.

POLICY:

Neighbor To Family uses disciplinary measures, behavioral supports, and teaching techniques that are trauma informed, strength-based, and that foster critical thinking and personal responsibility. Behavioral interventions and supports occur in an environment that is safe and secure which provides an opportunity for healthy growth and development.

Neighbor To Family develops and implements a comprehensive training program on the use of discipline, behavioral interventions, and teaching techniques including parameters for proper use and limitations on excessive or inappropriate use. Such training is mandatory for all personnel for whom discipline and behavioral interventions are part of their duties, including all foster parents, volunteers, interns, and front line staff.

PROCEDURE:

Neighbor To Family recognizes that circumstances with children may occur when the use of child control positions are necessary. This policy outlines procedures approved in non-emergency situations and in situations that require the application of emergency behavioral interventions to reduce or eliminate the risk of bodily harm to a child and/or to others. Neighbor To Family uses only those techniques that comply with relevant laws and regulations as set forth here and approved by the Board. Neighbor To Family does not use corporal punishment, mechanical or chemical restraints, isolation, seclusion, or confinement. Psychotropic medications are administered as prescribed and supervised by a licensed physician.

Definitions

1. Discipline: Discipline is used to help a child develop self-control, learn age-appropriate behaviors, and assume responsibility for their own actions.
2. Behavioral Intervention: Behavioral support and teaching techniques that are trauma informed and strength-based, that strive to eliminate coercion and coercive interventions, promote self-regulation and self-monitoring, and foster critical thinking and personal responsibility.
3. Emergency Situation: A situation in which attempted preventative de-escalatory or redirection techniques have not effectively reduced the potential for injury and it is immediately necessary to intervene to prevent:
    a. Imminent probable death or substantial bodily harm to the child because the child attempts or continually threatens to commit suicide or substantial bodily harm; or
    b. Imminent physical harm to another because of the child's overt acts, including attempting to harm others. These situations may include aggressive acts by the child, including serious incidents of shoving or grabbing others over their objections. These situations do not include verbal threats or verbal attacks.
4. Emergency Behavioral Interventions: A type of behavioral intervention that uses the application of physical force without the use of any device to restrict the free movement of all or part of a child's body in order to control physical aggression.
5. Child Control Position: A type of emergency behavioral intervention that protects the child from external danger that causes imminent significant risk to the child, such as preventing the child from running into the street or coming into contact with a hot stove.

A description of all physical symptoms resulting from psychotropic medications;Behavioral Intervention Plans

1. The Neighbor To Family team assigned to the family is responsible for designing, approving, implementing, monitoring, and supervising the implementation of behavioral interventions, if warranted. The development of the service plan may include a behavioral intervention plan to recognize and support positive behaviors and build on positive relationships and strengths by reinforcing positive behavior.

2. The development of the behavioral intervention plan includes the birth parent(s), Foster Caregiver(s), and the child, when appropriate, and requires their signature. (BSM 2.06)
3. The behavioral intervention plan, at a minimum, contains the following components: (BSM 2.02)
    a. An assessment of the child's psychological, social, and medical conditions or factors that could put the child at risk; medical factors may include issues related to medications, such as insulin imbalance; psychological and social factors may induce psychosis, history of abuse or other traumas, or claustrophobia;
    b. A common traumatic element is the massive control of one person over another. For individuals with a history of abuse or other traumas, undergoing a restrictive behavioral management intervention can be extraordinarily re-traumatizing; (BSM 2.05, 2.06)
    c. A detailed description of the full range of behavioral intervention procedures (intervention that is the least intrusive and least disruptive to the child, positive behavioral interventions, prompted relaxation, time out and child control position) or combination of procedures that may or may not be used, including operational details of the interventions themselves and a definition of each behavioral intervention;
    d. The plan will include statements describing the desired behavior in measurable terms and will be reinforced through recognition and/or rewards;
    e. Description of the use of emergency behavioral interventions, behavioral management techniques, or aversive procedures and identification of instances in which such procedures may be contraindicated;
    f. The plan identifies strategies to de-escalate behavior and prevent harassing, out-of control behavior;
    g. The plan takes into account an assessment of the antecedents to harassing, violent, or out-of-control behavior and the effective use of behavioral interventions; and
    h. The plan takes into full consideration the special needs of children with disabilities.

<u>Prohibition of Disciplinary Practices</u>

1. Neighbor To Family does not use corporal punishment, mechanical or chemical restraints, isolation, seclusion, or confinement as methods of

discipline; including the use of physical discipline by the Foster Caregiver on the Foster Caregiver's own children in the presence of the foster children (or within hearing of the Foster Caregiver physically disciplining them).

2. Neighbor To Family prohibits the use of aversive conditioning which includes, but is not limited to, any technique designed to or likely to cause a child physical pain; the application of startling stimuli; the release of noxious stimuli or toxic sprays, mists, or substances in proximity to the child's face; the use of pressure points, rebirthing therapy, and hug and/or restraining therapy.
3. Neighbor To Family prohibits drug use as a restraint; a drug used as a restraint shall be employed only if required to treat a medical condition. It shall not be employed for the purpose of punishment, Foster Caregiver convenience, or as a substitute for adequate supervision.
4. At initial intake, the birth parent(s), Foster Caregivers, and children age five (5) years and older are informed of the following behaviors or actions that are strictly prohibited against any child served by the Agency:
    a. Corporal punishment which may include physical hitting or any type of physical punishment inflicted in any manner upon the body;
    b. Use of discipline by peers or any other person other than a trained, qualified staff or Foster Caregiver; (BSM 2.03)
    c. The use of excessive or unnecessary force or child control position, except when a child is in imminent risk of harm to himself or others until the child is calm;
    d. A child of any age may not be shaken;
    e. Subjecting to cruel, severe, or unusual punishment;
    f. Putting anything in or on a child's mouth, such as soap or tape;
    g. Putting anything in or on a child's mouth, such as soap or tape;
    h. Requiring or using force to require the child to take an uncomfortable position such as squatting, bending, or repeated physical movements;
    i. Meaningless work as punishment, and emotionally demeaning or humiliating actions or consequences;
    j. Subjecting to verbal remarks which belittle or ridicule the child or his or her family, or any other form of verbal abuse, humiliation, threats about the child and/or his or her family, or derogatory remarks under any circumstances;
    k. Denying emotional response as punishment;

l. Placing the child in a locked room, or in a dark room, bathroom, or closet;
m. Confining the child to a highchair, box, or other similar furniture or equipment as discipline or punishment;
n. Depriving of clothing;
o. Depriving of sleep;
p. Depriving of visits or weekly telephone contacts with family, attorneys or their legal assistants, assigned workers, or other persons who have established a significant bond with the child;
q. Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age;
r. Depriving of items necessary for personal hygiene;
s. Depriving of a daily shower/bath, access to a toilet or water;
t. Subjecting to unclean or unsanitary living conditions;
u. Disciplining for toilet accidents;
v. Depriving of health care, including counseling;
w. Depriving of a meal or part of a meal;
x. Depriving of exercise;
y. Depriving of an opportunity to attend religious services and/or religious counseling of his or her choice;
z. Denying essential program services as punishment;
aa. Threatening with being moved from foster home; and
ab. Harassing or violent behavior by others. (BSM 2.02)

5. Employment of inappropriate/prohibited disciplinary practices will result in the immediate dismissal of the Foster Caregiver from the caretaker role and may result in a Child Protection investigation.

Discipline

1. Discipline is used to help a child develop self-control, learn age-appropriate behaviors, and assume responsibility for their own actions. (BSM 1.02)
2. When behavioral consequences are imposed, Neighbor To Family Foster Caregivers and staff will:
   a. Talk to the child and explain the reasons why his or her choice of behavior led to the consequences being imposed;
   b. Allow the child an opportunity to explain the reasons behind his or her conduct; and
   c. Document the nature of the incident and the consequences in the client record.
3. The use of discipline is limited as follows:

a. Discipline is initiated as soon as possible after the occurrence of the inappropriate behavior;
b. Discipline is not out of proportion to the particular inappropriate behavior; and
c. Discipline is not delegated to a child's peers.

4. Documentation of discipline and behavioral interventions:
   a. Details the purpose, scope, and limitations of the technique;
   b. Clearly describes the methods and procedures for administering the technique delineating authority and responsibility by position as applicable; and
   c. Provides for administrative or supervisory review.
5. Acceptable discipline includes:
   a. Use of child discipline that is appropriate to the child's chronological age, mental age, emotional make-up, and experience;
   b. Talking to the child and explaining the reasons why his or her choice of behavior led to the consequences being imposed;
   c. Allowing the child an opportunity to explain the reasons behind his or her conduct;
   d. Giving logical consequences that are appropriate to the situation and severity of the behavior, including assigning special or additional tasks and/or withholding privileges;
   e. Withholding the child's personal spending money to pay for damages done by the child or for breaking a rule(s) when the child has been warned that spending money will be withheld as a consequence;
   f. Using praise, positive reinforcement, and encouragement of good behavior instead of focusing only on unacceptable behavior;
   g. Giving the child acceptable choices or alternatives;
   h. Using brief supervised separation or time away from the group or situation, when appropriate for the child's understanding, age, and development, to regain composure or reflect on choice of behavior. (Best practice suggests that quiet time or time out from the group is limited to no more than one (1) minute per year of the child's chronological or developmental age. However, this time frame may need to be adjusted for some children, such as a child who has Attention Deficit Disorder. Time out is not appropriate for infants and is not recommended for toddlers, since they are too young to understand this intervention.);
   i. Reminding a child of behavior expectations daily by using clear, firm, positive statements;

   j. Redirecting the child's attention or behavior using positive statements;
   k. Focusing on the rule to learn and the reason for the rule;
   l. Focusing on solutions that are respectful, reasonable, and related to the problem behavior, rather than blaming or focusing on consequences;
   m. Providing prior notice of possible consequences for inappropriate behaviors; and
   n. Arranging the environment to allow safe testing of limits.
6. Neighbor To Family recognizes that circumstances with a child may occur when the use of emergency behavioral interventions are necessary. However, only Foster Caregivers who are trained and qualified in emergency behavioral intervention techniques by the Crisis Institute may administer intervention, when the least restrictive discipline methods have proven to be ineffective.
7. Within limits, a Foster Caregiver may restrict a child's activities as a behavioral intervention tool. Restrictions of activities, other than school or chores, which will be imposed on a child for more than thirty (30) days, must be reviewed with and approved by the Case Manager's Supervisor or the Therapist prior to or within twenty-four (24) hours of imposing the restriction, and documented in progress notes.
8. Restrictions to a particular room or building that will be imposed on a child for more than twenty-four (24) hours must have approval from the Case Manager's Supervisor or the Therapist prior to or within twenty-four (24) hours of imposing the restriction; and documentation of all approvals, justification for the restriction, and informing the child and parent(s) must be in the client record.

Child Control Position

1. In circumstances when a child's behavior cannot be controlled by using one or more of the child control position techniques, the police are to be called (at 911). As outlined in this procedure, a Foster Caregiver and/or qualified staff may administer the following types of child control positions to a child in care:
   a. To protect the child from external danger that causes imminent significant risk to the child, such as preventing the child from running into the street or coming into contact with a hot stove. The position must end immediately after the danger is averted;
   b. To intervene when a child under the age of five (5) years old (chronological or developmental age) demonstrates disruptive

behavior, if other efforts to de-escalate the child's behavior have failed;

c. When a child over five (5) years old demonstrates behavior disruptive to the environment or milieu, such as disrobing in public or provoking others, that creates a safety risk, or to intervene to prevent a child from physically fighting;
d. In a foster home where a child is significantly damaging property, such as breaking car windows or putting holes into walls. If this is the basis of the child control position, only a short child control position may be used and only to prevent the damage; using the minimum amount of physical contact or force needed to effectively prevent a child from causing injury to him or her, personnel or others, or damage to property; and
e. A child control position is administered in such a manner as to avoid provoking further aggressive behavior.

2. The following shall apply when administering child control positions:
   a. Before employing a child control position, the Foster Caregiver shall take into consideration the child's medical condition and any medications the child may be taking;
   b. The child's history of abuse and trauma;
   c. No child shall be physically restrained utilizing a protective or mechanical device;
   d. A child control position shall:
      i. Not be used as a form of discipline or convenience, only administered when there is imminent risk of harm to the child and others, or other less restrictive approaches have failed, and ends when the child becomes calm; and
      ii. When a Foster Caregiver implements a child control position, the Foster Caregiver must:
         1. Monitor the child's breathing;
         2. Minimize the risk of physical discomfort, harm, or pain to the child;
         3. Use the minimal amount of reasonable and necessary physical force;
         4. Ascertain that the child is verbally responsive and in control of all motor skills; and
         5. The child control position must be discontinued as soon as possible, and is limited to fifteen (15) minutes for children ages nine (9) and younger and thirty (30) minutes for children ages ten (10) and older. (BSM 5.06)

6. Use or continued use of the child control postion must be authorized and/or reauthorized by the Executive Director of the Program Site. For example, in cases where the child continues not to follow verbal commands or continues to be out of instructional control after the initial 15 minutes and/or initial 30 minutes of use of the child control positon; authorization must be obtained.

3. If, at any time, during the administration of the child control position the child complains of being unable to breath or loses motor control, the Foster Caregiver administering the child control position shall immediately terminate or adjust the position to ensure that the child's breathing and motor control are not restricted. If, at any time, the child appears to be in distress, the Foster Caregiver shall immediately seek medical attention for the child.
4. A Foster Caregiver may not use any of the following techniques as a child control position:
   a. A prone or supine position;
   b. A position that impairs the child's breathing by putting pressure on the child's torso, including leaning a child forward during a seated position;
   c. A position that obstructs the airways of the child or impairs the breathing of the child, including procedures that place anything in, on, or over the child's mouth, nose, or neck, or impede the child's lungs from expanding;
   d. A position that obstructs the Foster Caregiver's view of the child's face;
   e. A position that interferes with the child's ability to communicate or vocalize distress; or
   f. A position that twists or places the child's limb(s) behind the child's back.
5. Following the use of a child control position, the child will be continuously supervised, face to face, and assessed every fifteen (15) minutes (BSM 5.02) by the Foster Caregiver or staff for a period of four (4) hours to monitor and evaluate the child's physical and emotional well-being. Observations will be documented on the Emergency Behavioral Intervention Log. The Behavioral Intervention Log will be reviewed by the program or clinical director no later than one (1) working day following the incident. (BSM 1.04)

Psychotropic Medications

1. Psychotropic medications are administered to children with an Axis One Diagnosis and must be prescribed by a licensed physician who has personally examined the child prior to prescribing the medication.
2. Neighbor To Family obtains the informed, written consent of the parent, legal custodian, or the person legally authorized to give medical consent(s) (Consent for Psychotropic Medication) and complies with the Agency's policy for the Storage and Administration of Medication.
3. The medication is a part of the mental health component of the child's service plan, and is under the direct management and supervision of the treating physician:
    a. All documentation pertaining to the child's service plan must be included in the client record:
        i. A description of all physical symptoms resulting from psychotropic medications;
        ii. The intended effect of prescribed psychotropic medication;
        iii. The prescribed duration and dosage of the medication;
        iv. The relationship of the medication to other forms of treatment;
        v. A description of any other medication being given to the child; and
        vi. A copy of the written consent included in the client record.

Staff Training

1. Neighbor To Family Foster Caregivers receive twelve (12) hours of mandatory training on discipline and behavioral interventions. Personnel receive a comprehensive orientation and job requirement training on different levels. (BSM 5.01)
2. Such training is mandatory for all personnel for whom discipline and behavioral interventions are part of their duties, including all Foster Caregivers, others as directed, volunteers, interns, and front line staff.
3. Foster Caregivers and staff who utilize child control positions will receive at least eight (8) hours of training in behavioral management, including techniques for de-escalating problem behavior, the appropriate use of child control positions, monitoring of vital indicators, and debriefing children and parents involved in child control position incidents.
4. Thereafter, the Agency shall ensure that Foster Caregivers and staff authorized to use child control positions annually complete at least

eight (8) hours of behavioral management training, including techniques for de-escalating problem behavior.
5. Written training material is provided.
6. Training is offered at frequent intervals so that all new personnel and those needing retraining receive it as soon as possible.

Debriefing

1. The Case Manager or Therapist will conduct a debriefing in a safe, confidential setting within twenty-four (24) hours of the occurrence and will include the staff assigned to the child, the child, the Foster Caregiver, and parents or legal custodian to:
   a. Evaluate the physical and emotional well-being;
   b. Identify the need for counseling or other services related to the incident;
   c. Identify antecedent behaviors and modify the service plan as appropriate;
   d. Assess the child's psychological, social, and medical conditions or factors that could put the child at risk; and (BSM 2.06)
   e. Facilitate the child's reentry into routine activities.
2. The Foster Caregiver or staff involved in the incident is debriefed to assess:
   a. Their current physical and emotional status;
   b. The precipitating events; and
   c. How the incident was handled and necessary changes to procedures and/or training to avoid future incidents.
3. Other person involved in, or witness to, the incident is debriefed to identify possible injuries and emotional reactions.
4. The Case Manager or Therapist will document the planning and debriefing conducted with the child and the Foster Caregiver to eliminate or reduce probability of reoccurrence. BSM 6.02, BSM 6.03, BSM 6.04
5. The Executive Director of the Program Site will be included in all debriefings related to the authorization or reauthorization of Child Control Positions. BSM 5

Documentation

1. At the initial intake, the birth parent(s), Foster Caregivers, and children ages five (5) years and older will receive an explanation and a copy of the Discipline and Behavioral Intervention policy, and sign an

Acknowledgement of Receipt of Discipline and Behavioral Intervention Policy.

2. The use of emergency behavioral interventions requires the consent of the birth parent(s) or legal custodian. (Consent for Emergency Behavioral Intervention) BSM 2.01
3. Non-emergency interventions are reviewed for effectiveness and appropriateness, on a monthly basis, as a part of the child's service/case plan. Interventions are based on the individual's needs and are designed to eliminate aggressive behaviors and promote self-control and personal responsibility.
4. The Foster Caregiver is required to make a verbal report to the Case Manager immediately following the utilization of an emergency behavioral intervention.
5. All incidents will be reported consistent with Neighbor To Family's Incident Reporting Policy.
6. The Behavioral Intervention Log will document the clinical justification, technique used, circumstances, length of application, name of the child and the personnel involved, other person present when the child control position was utilized, if appropriate, total number of child control positions of the child since placement in the Foster Caregiver's home, and signature of the person completing the Behavioral Intervention Log which will be attached to the Incident Report. (BSM 6.01)
7. The Agency will conduct quarterly risk management reviews of all emergency behavioral interventions to ensure the Agency is meeting the standards of this policy as well as to review how the Agency's practices compare with current information and research on effective practice. (BSM 1.03, PQI 2.02, & RPM 2.02) The Agency will include in the annual Performance and Quality Improvement Report a summary of the findings and any action taken during the year based on the findings.
8. Any act of omission or commission by a Foster Caregiver or other member of the household which results in the death, injury, illness, abuse, neglect, or exploitation of a foster child shall be grounds for the denial or revocation of a foster home certificate.

Reference:

COA Behavior Support and Management: BSM 1.01, BSM 1.02, BSM 1.03, BSM 1.04, BSM 2.01, BSM 2.02, BSM 2.03, BSM 2.04, BSM 2.05, BSM 2.06; BSM 5.01, BSM 5.02, BSM 5.03, BSM 5.04, BSM 5.05, BSM

5.06; BSM 6.01, BSM 6.02, BSM 6.03, BSM 6.04; Related RPM 2.02, PQI 2.02, RPM 2.02, AM-RM-012