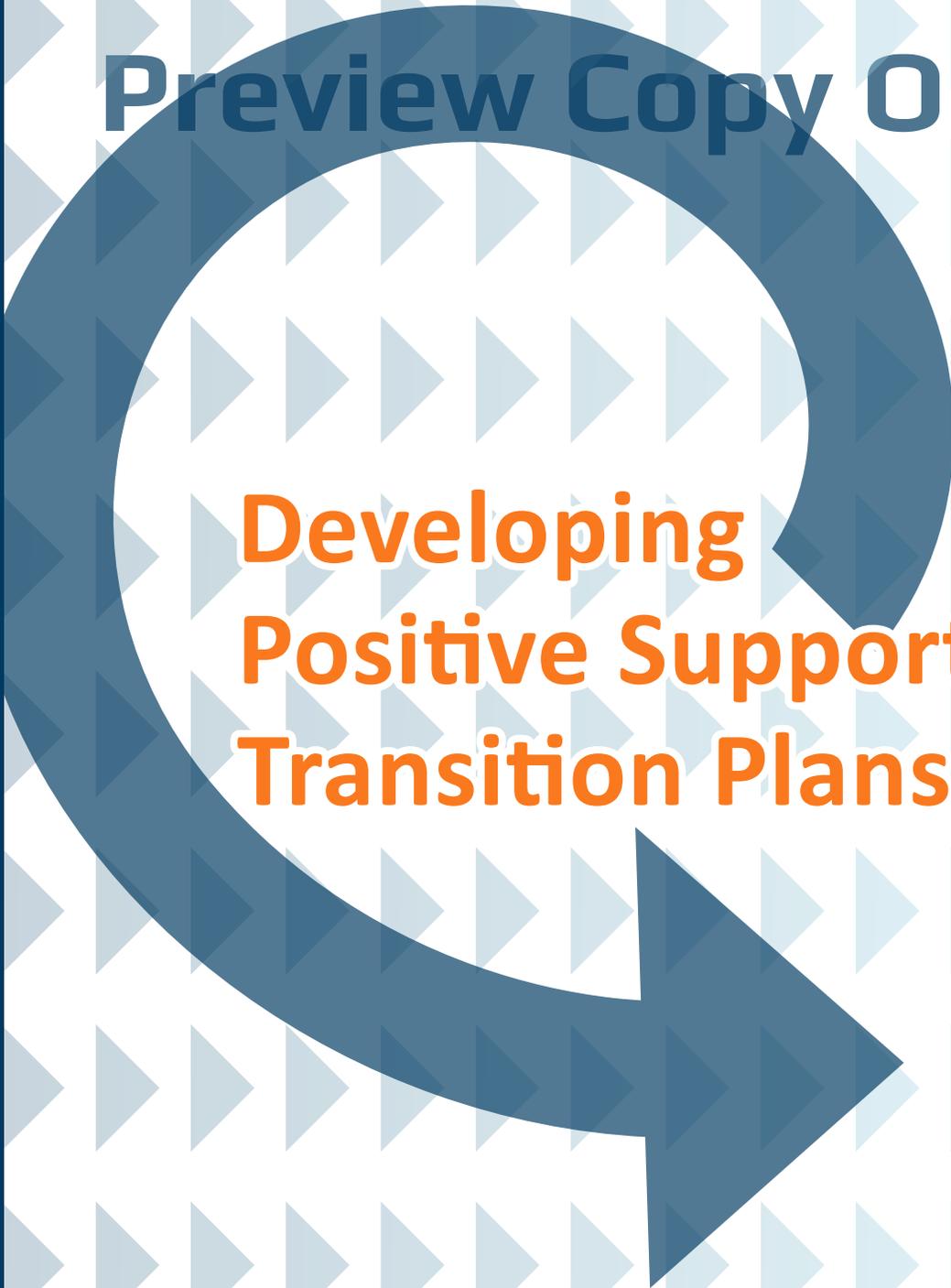


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Developing Positive Support Transition Plans

***A Provider Guide for 245D-Licensed
Home and Community-Based Services
in Minnesota***

Developed by the Disability Services Division of the Continuing Care
Administration Minnesota Department of Human Services

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Preface

“Ensuring Minnesotans we care for are treated with respect and dignity is a key element of our agency’s mission. Practices around seclusion and restraint have not always been consistent with these principles ...To that end, it is our goal to prohibit procedures that cause pain, whether physical, emotional or psychological, and prohibit the use of seclusion and restraints for all programs and services licensed or certified by the department. It is our expectation that service providers will seek out and implement therapeutic interventions that reflect best practices.”

—DHS Respect and Dignity Practices Statement

This Guide has been developed for providers licensed under [Minnesota Statute 245D: Home and Community-Based Services Standards](#) to better understand the requirements related to developing Positive Support Transition Plans. The purpose of a Positive Support Transition Plan (PSTP) is to incorporate positive support strategies into a person’s life to eliminate the use of aversive procedures, to avoid the emergency use of manual restraint, and to prevent the person from physically harming self or others.

These new plans are to be developed for persons with developmental disabilities who currently have a “Rule 40,” plan (for the programmatic use of aversive procedures to control behavior, de-escalate mental health symptoms, or respond to a crisis). The plans also are to be developed for certain other persons with mental illness, traumatic brain injuries, dementia, or other acquired conditions as cited in the statute.

[Minnesota Administrative Rules 9525.2700 to 9525.2810](#), known as “Rule 40” began in 1987 and set guidelines regarding the use of aversive procedures (including deprivation and punishment). At the time Rule 40 was implemented, the rules were intended to reflect best practices. During the course of a 2009 court case, Jensen et al. vs. Minnesota Department of Humans Services, it was determined that they no longer do.

In accordance with the Jensen settlement agreement, a Rule 40 Advisory committee was assembled to make recommendations on how to modernize Rule 40. Guided by the work and recommendations of the Rule 40 Advisory Committee, this Guide is a starting point for providers—the Minnesota Department of Human Services (DHS) will be developing additional tools and resources over the next year to increase capacity in the area of positive supports in the provider community

Mission, Values and Goals

of the Department of Human Services-Continuing Care Administration

Mission Statement:

The Continuing Care Administration strives to improve the dignity, health and independence of the people we serve.

Vision Statement

Minnesotans will:

- a. Live as independently as possible
- b. Enjoy health, with access to quality to health care
- c. Have safe, affordable places to live
- d. Be contributing and valued members of their communities
- e. Participate in rewarding daily activities, including gainful employment

Values Statement

In supporting this vision, we value:

- a. Self-determination
- b. Personal responsibility
- c. Integrity
- d. Diversity
- e. Partnerships
- f. Accountability

Disability Services Division Goals

- Goal 1:** Improve service and administration to increase access, consistency, transparency and accountability
- Goal 2:** Provide access to the right service at the right time
- Goal 3:** Provide accountability to/and improve quality
- Goal 4:** Strengthen partnerships and collaboration
- Goal 5:** Foster a shared vision and a culture of innovation
- Goal 6:** Make person centered assessment and decision making the foundation of the service system

Disability Services Division's "Domains of a Meaningful Life"

- C**ommunity Membership;
- H**ealth, wellness and safety;
- O**wn place to live;
- I**mportant long-term relationships;
- C**ontrol over supports and;
- E**mployment earnings and stable income.

Part 1:

Evolution of the Positive Support Transition Plan

Recent events, including the *Olmstead* decision, Minnesota Department of Human Services' (DHS) Reform 2020, an investigation by the Minnesota Ombudsman for Mental Health and Developmental Disabilities, and the settlement of a class action lawsuit led to the formation of the *Rule 40 Advisory Committee* whose goal was to “modernize” Rule 40.

A major part of the class action lawsuit, known as the [Jensen Settlement](#), involves the elimination of aversive procedures. The settlement requires the state of Minnesota and DHS to “immediately and permanently discontinue the use of mechanical restraint (including metal law enforcement-type handcuffs and leg hobbles, cable tie cuffs, PlastiCuffs, FlexiCuffs, soft cuffs, Posey Cuffs, and any other mechanical means to restrain), manual restraint, prone restraint, chemical restraint, seclusion, and the use of painful techniques to induce changes in behavior through punishment of residents with developmental disabilities.”

In addition to persons with developmental disabilities, DHS has determined that prohibited techniques should apply to every person, including those with mental illness, traumatic brain injury, dementia, or other acquired condition that were not previously subject to Rule 40.

The Olmstead Decision

In 1999, the United States Supreme Court held in *Olmstead v. L.C.* that “unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act” (U. S. Department of Justice, 2013). The decision compels states to ensure the development of community support plans for individuals with disabilities. These plans are consistent with the principles of the “most integrated setting” and “person centered planning”.

The Jensen settlement agreement included a provision calling for the development and implementation of a [Minnesota Olmstead Plan](#) and Governor Dayton issued an executive order forming the Olmstead Subcabinet to develop such a plan. On November 1, 2013, the plan was released and covers these broad topic areas: Employment, housing, transportation, supports and services, lifelong learning and education, healthcare and healthy living, and community engagement.

First year activities detailed in the plan include:

- a. Concrete changes to reduce the number of people in segregated service settings
 - b. Expansion of effective transitions from high school to postsecondary education or training programs
 - c. Expansion of self-advocacy and peer support options
 - d. Increased individual control over housing
 - e. Increased individual control over support services, such as personal care assistance
 - f. Increased integrated employment opportunities
 - g. *Movement toward positive practices and away from use of seclusion, restraints and other restrictive practices***
 - h. New practices to improve health outcomes
- MOVEMENT TOWARD
POSITIVE PRACTICES
AND AWAY FROM USE OF
SECLUSION, RESTRAINTS
AND OTHER RESTRICTIVE
PRACTICES**

There are four main strategic actions for DHS to take on to ensure quality and accountability **to ensure the individual person is the focus of services and support:**

- a. Quality of life measurement
- b. Dispute resolution process for individuals with disabilities
- c. Oversight and monitoring implementation of the plan
- d. Quality improvement

In July 2013, the Rule 40 Advisory Committee released its [*Recommendations on Best Practices and Modernization of Rule 40*](#). From the introduction:

The Rule 40 Advisory Committee provides their recommendations to the Minnesota Department of Human Services to modernize...“Rule 40,”to reflect current best practices when providing services to individuals with disabilities. Current best practices include, but are not limited to, the use of positive and social behavioral supports, prohibitions on use of restraints and seclusion, trauma informed care, and the development of community support plans that are consistent with the principles of the “most integrated setting” and “person centered planning,” consistent with the [Olmstead decision]. The outcome of these practices is to increase quality of life, and appropriately respond to the behavior of the person. The advice and recommendations of the advisory committee is the product of many hours of meetings, contemplation, research and discussions.

Reform 2020

In 2011, the Minnesota Legislature directed DHS to reform Medical Assistance, Minnesota’s Medicaid program, to achieve better outcomes for people with disabilities, seniors and other enrollees. Federal approval has been attained so the state can make changes in the areas of community integration and independence, improved health, reduced reliance on institutional care, attainment of housing and employment and reduced use of services that are less effective. This initiative is called [*Reform 2020*](#). Reform 2020 provides the foundation for changes in Home and Community Based (HCBS) Waiver Provider Standards found in Minn. Stat. §245.D.

Minnesota Legislative Response

Influenced by these events and recommendations, in 2013 the Minnesota State Legislature amended [*Minnesota Statute 245D: Home and Community-Based Services Standards*](#) (Minn. Stat. §245D). The statute describes responsibilities of organizations that provide services and support to people with disabilities and people over the age of 65 who receive services funded through a waiver. This includes people with developmental disabilities, mental illness, traumatic brain injuries, dementia, or other acquired disabilities.

A key part of the statute is the requirement for service providers to phase out and then eliminate the use of aversive procedures to control behavior, de-escalate mental health symptoms, or respond to a “crisis.”

Specifically, [Protection Standards, Section 245D.06, Subdivision 5](#) prohibits the following procedures, known as behavior or “target” interventions as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience:

1. **Chemical restraint:** The administration of a drug or medication to control the person’s behavior or restrict the person’s freedom of movement and is not a standard treatment or dosage for the person’s medical or psychological condition.
2. **Mechanical restraint:** The use of devices, materials, or equipment attached or adjacent to the person’s body, or the use of practices that are intended to restrict freedom of movement or normal access to one’s body or body parts, or limits a person’s voluntary movement or holds a person immobile as an intervention precipitated by a person’s behavior.
3. **Manual restraint** (Except in an emergency): physical intervention intended to hold a person immobile or limit a person’s voluntary movement by using body contact as the only source of physical restraint.
4. **Time out:** Removing a person involuntarily from an ongoing activity to a room, either locked or unlocked, or otherwise separating a person from others in a way that prevents social contact and prevents the person from leaving the situation if the person chooses.
5. **Seclusion:** The placement of a person alone in a room from which exit is prohibited by a staff person or a mechanism such as a lock, a device, or an object positioned to hold the door closed or otherwise prevent the person from leaving the room.
6. **Aversive procedures:** The application of an aversive stimulus contingent upon the occurrence of a behavior for the purposes of reducing or eliminating the behavior.
7. **Deprivation procedures:** The removal of a positive reinforcer following a response resulting in, or intended to result in, a decrease in the frequency, duration, or intensity of that response.

In addition to the elimination of these interventions, the statute requires service providers to incorporate “positive supports.” Positive supports are non-aversive interventions designed to decrease crisis situations and ensure the safety of and improve the quality of life of persons covered by the statute.

Providers must also document the elimination of prohibited procedures and the incorporation of positive supports in the person’s [Positive Support Transition Plan](#). Instructions for completing the PSTP can be found at [Positive Support Transition Plan Instructions](#).

Quality of Life

As PSTPs are developed, particular attention will be given to incorporating quality of life measures into individual outcomes. The Disability Services Division focuses on six domains of a meaningful life known as [CHOICE](#). These domains are integrated into The Minnesota Olmstead Plan. The Minnesota Olmstead Plan includes the provision that “Minnesota will conduct annual surveys of people with disabilities to determine quality of life.”

The surveys will be designed to determine:

- a. How well people with disabilities are integrated into and engaged with their community.
- b. How much autonomy people with disabilities have in day to day decision making.
- c. Whether people with disabilities are working and living in the most integrated setting that they choose.

The plan describes how the selected survey instrument will be developed incorporating these domains:

1. Engagement in preferred activities
2. Physical integration
3. Social integration in the community
4. Physical health
5. General positive affect
6. Opportunities for goal attainment
7. Increased independence/living skills
8. Work performance
9. Memory and concentration

The use of positive supports begins with examining and meeting the needs of the individual person through person-centered planning (discussed in [Part 3](#)). Positive supports also result from evidenced-based interventions (such as Positive Behavior Supports, discussed in [Part 4](#)).

Effective July 1, 2013, the statute requires providers, including intermediate care facilities for persons with developmental disabilities (ICF/DDs) and others licensed under Minn. Stat. §245D, to complete and submit a [Behavior Intervention Reporting Form DHS-5148](#), also known as BIRF, to report all occurrences of any of the following:

- a. Planned use of controlled procedures
- b. Emergency use of controlled procedures
- c. Emergency use of manual restraint

Developing the PSTP

A qualified designated coordinator, behavior analyst or behavior professional must develop the PSTP with considerable input from the person and from his or her support team. Those who provide direct contact/services will implement the plan, monitor progress, collect data, and provide feedback.

The foundation of creating a PSTP is a functional behavior assessment. This assessment defines the problem behaviors, identifies the situations during which the behaviors are likely to occur or not occur, generates a hypothesis of why the behavior occurs, and provides reliable evidence to support the hypothesized function.

As noted in Appendix B, behavior can stem from a number of factors: Physiological, social, psychological, and environmental. The functional behavior assessment is a tool to help determine specific factors that contribute to problem behavior(s) that will become the targets of a positive support strategy.

PSTPs have eight parts:

1. Background information on the person
2. Target interventions to be eliminated
3. Target behaviors identified for elimination
4. Crisis support planning and response
5. Quality of life indicators
6. Data collection methods
7. Authorship and consent
8. Positive Support Transition Plan review

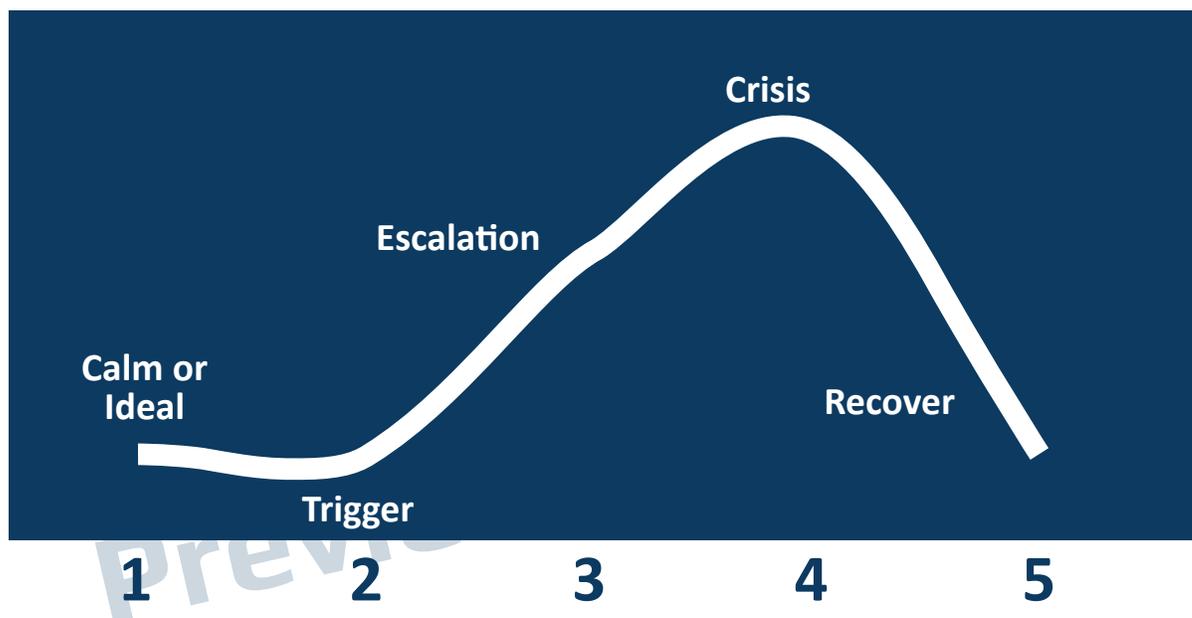
For persons who need a PSTP, the case manager shall participate in the development and ongoing evaluation of the plan. At least quarterly, the case manager shall evaluate the effectiveness of the plan based on progress evaluation data submitted by the licensed provider to the case manager. The evaluation must identify whether the plan has been developed and implemented in a manner to achieve the following within the required timelines:

- a. Phasing out the use of prohibited procedures
- b. Acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline
- c. Accomplishment of identified outcomes

See Part 5 for a sample PSTP.

Part 2: Crisis Planning

The prohibition of the target interventions described above requires providers to engage in crisis planning for the persons they serve. The Minnesota Department of Human Services (DHS) uses a crisis framework comprised of five stages as depicted in the diagram below:



DHS uses this framework to promote a common understanding and reporting of crises. For the purposes of the Positive Supports Transition Plan (PSTP), “crisis” refers to a situation that exceeds a person’s resources and coping mechanisms and has the potential to endanger their health and safety of or the health and safety of others. The framework can also help teams look at ways of reducing recurring crises.

The **calm or ideal stage** indicates what typical or calm functioning would look like for a person. “Calm or ideal” varies for every person and/or event. Teams identify the person’s optimal state and past support strategies to help the person maintain this state.

The **trigger stage** indicates situations, words, people, decisions, critical periods, etc. that can set a person towards a crisis (triggers are considered antecedent events). The idea behind crisis prevention is that a team assists a person to either avoid or cope with triggers. The person and their team must decide which method of crisis prevention is best suited to each trigger. Teams identify proactive and reactive ways to support a person when encountering triggers. Proactive strategies focus on strategies to use before a known trigger/antecedent will be encountered. Reactive strategies focus on strategies to use after encountering a trigger/antecedent.

Sample Triggers

Physiological	Environmental	Psychological	Social
Allergies	Air quality	Anxiety	Being stared at
Cravings	Proximity to others	Boredom	Change in staff
Earaches	Lighting	Depression	Criticism
Headaches	Limited physical space	Fear	Disapproval
Hunger	Noise	Phobias	Not having choices
Itching	Smells	Paranoia	Relocation
Pain	Temperature	Sexuality issues	Teasing by others
Thirst	Time	Transitions	Tone of voice

De-escalation is the planful way of limiting the impact of a crisis. On a long-term basis, people who may have crisis events should have support plans (including de-escalation procedures) that include environmental accommodations, therapies, health care and medications, opportunities to develop strong relationships, work and volunteer opportunities, education, and/or community involvement that could, in part, alleviate symptoms and to avoid crises.

The **escalation stage** refers to the behaviors or symptoms that typically emerge after a trigger and before a crisis. This is a critical period in which there is an opportunity to assist a person to avoid a crisis.

Because crises often endanger someone's health and safety, an intervention is typically necessary. When a **crisis stage** poses a risk of injury to someone and all other intervention methods have failed, the crisis becomes an emergency safety situation.

According to [Minn. Stat §245D.061](#), the crisis stage is the only time when emergency use of manual restraint is allowable. For license holders who do not use emergency use of manual restraint, another intervention strategy must be identified, such as calling a crisis line or 911.

The **recovery stage** refers to the period just after a crisis as people or events are on their way back to the calm or ideal phase. The goal of the recovery stage is to assist a person in returning to the calm or ideal stage. Strategies for support may include debriefing with the person, suggesting the person call a friend, or giving the person space.

Manual Restraint

Even in cases when a Positive Support Transition Plan is in place, [Minn. Stat. §245D.061](#) does allow for the “emergency use of manual restraint.” However, this use must meet both of the following conditions:

1. Immediate intervention must be needed to protect the person or others from imminent risk of physical harm. (Property damage, verbal aggression, or a refusal [to receive or participate in treatment or programming] do not constitute an emergency.)
2. The type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety. The manual restraint must end when the threat of harm ends.

IF A PROVIDER DOES NOT ALLOW FOR THE EMERGENCY USE OF MANUAL RESTRAINT, THEY MUST DETERMINE WHAT MEASURES WILL BE TAKEN TO PROTECT THE HEALTH AND SAFETY OF THE PERSONS THEY SERVE DURING A CRISIS.

Providers will determine if they will allow the emergency use of manual restraint. Providers that do allow the emergency use of manual restraint must submit an *Emergency Use of Manual Restraint (EUMR) policy statement*.

If a provider does not allow for the emergency use of manual restraint, they must determine what measures will be taken to protect the health and safety of the persons they serve during a crisis. These alternate measures must be identified and documented in the provider’s policies and procedures.

Sample statements that providers can customize are available on the DHS Website:

- a. [Sample Policies and Forms for Basic Supports and Services](#)
- b. [Sample Policies and Forms for Intensive Supports and Services](#)

Note: In addition to the sample documents related to the emergency use of manual restraint, these web pages have other samples of related forms that 245D licensed providers may link to and modify for use in their programs.

Planning for and Responding to Other Incidents

Besides a EUMR policy statement, providers licensed under Minn. Stat. §245D must have a policy and plan for responding to all “incidents.” Incidents are occurrences, which involve a person and require the program to make a response that is not a part of the program’s ordinary provision of services to that person. These include:

1. Serious injury of a person
2. A person’s death
3. Any medical emergency, unexpected serious illness, or significant unexpected change in an illness or medical condition of a person that requires the program to call 911 or arrange physician treatment or hospitalization
4. Any mental health crisis that requires the program to call 911 or a mental health crisis intervention team
5. Any act or situation involving a person that requires the program to call 911, law enforcement, or the fire department
6. A person’s unauthorized or unexplained absence from a program
7. Conduct by a person receiving services against another person receiving services that is so severe, pervasive, or objectively offensive that it substantially interferes with a person’s opportunities to participate in or receive service or support; places the person in actual and reasonable fear of harm; places the person in actual and reasonable fear of damage to property of the person; or substantially disrupts the orderly operation of the program
8. Any sexual activity between persons receiving services involving force or coercion
9. Any emergency use of manual restraint
10. A report of alleged or suspected child or vulnerable adult maltreatment

The plan must provide 1) the contact information of a source of emergency medical care and transportation; 2) require staff to first call 911 when the staff believes a medical emergency may be life threatening, or to call the mental health crisis intervention team when the person is experiencing a mental health crisis; and 3) a procedure for the review of incidents and emergencies to identify trends or patterns, and corrective action if needed.

Details for responding to all incidents are found in section [Minn. Stat. §245D.02 Subd. 11](#) and for reporting all incidents are found in section [Minn. Stat. §245D.02 Subd. 1](#).

Part 3:

Positive Support Transition Plans and Person-Centered Planning

Person-centered planning is the first step of service planning and delivery under [Minn. Stat. §245D.07](#). The statute specifically requires that person-centered service and planning:

1. Identifies and supports what is important to the person and what is important for the person including preferences for when, how, and by whom direct support service is provided
2. Uses information to identify outcomes the person desires
3. Respects each person's history, dignity, and cultural background

The person-centered planning process begins with listening to the person and honoring his or her vision for their life.

The Rule 40 Advisory Committee described person-centered planning as a cluster of approaches to organizing and guiding community change in alliance with persons with disabilities and their families and friends. Person-centered planning is a strategy used to facilitate team-based plans for improving a person's quality of life as defined by the person, their family, and other members of the community.

Person-centered planning focuses on the person's preferences, talents, dreams, and goals. In any person-centered plan, the person must always be at the center of the process. The process of person-centered planning includes strategies to increase 1) the person's quality of life, 2) relationships, and 3) activities that build on their strengths, priorities, values, and preferences. The desired outcome of a person-centered plan is a better life for the child or adult.

When developing Positive Support Transition Plans, engaging in person-centered planning helps identify what is **important to** a person as well as what is **important for** a person. This is a core concept taught in the Person-Centered Thinking and Planning Training developed by Support Development Associates that DHS is implementing statewide. Balancing what is important to a person and what is important for a person is a useful tool to attain the goal of a valued, active life.

WHEN DEVELOPING POSITIVE SUPPORT TRANSITION PLANS, ENGAGING IN PERSON-CENTERED PLANNING IDENTIFIES WHAT IS **IMPORTANT TO A PERSON AND WHAT IS IMPORTANT FOR A PERSON.**

What is **important to** a person includes those things in their life that help them to be satisfied, content, comforted, and happy. Things important to a person might include:

- a. Relationships with others
- b. Things to do or to own
- c. Places to go
- d. Rituals and routines
- e. Rhythm or pace of life
- f. Status and control

The key in person-centered planning is that the things that are most important to a person are expressed in their own words or actions (Support Development Associates, n.d.).

What is **important for** a person focuses on issues of health, safety, and what others see as necessary to help the person become a valued and contributing member of their community. Issues of health and safety include preventing illness, treating illness and or medical conditions, and promoting wellness such as through diet and exercise. Issues of safety include environment, physical and emotional well-being, and freedom from fear (Support Development Associates, n.d.).

A person-centered plan that balances what is important to and important for a person and the actions necessary to support them, may result in the elimination of the need for a targeted intervention because the behavior has stopped.

Person-centered planning processes differ from traditional intervention planning in a number of ways. Traditional approaches have often focused on fixing a person's problems to create access to community life. Many times in meetings someone will say, "As soon as she can control her behavior, she can ...go to a girl scout meeting ...get a job ...go to the movies ...live independently" (Kansas Institute for Positive Behavior Support, 2012; University of Minnesota Positive Behavior Support Initiative, n.d.).

These professional-driven models target the changes a person needs to make to fit into society, rather than empowering the person to foster choices that increase and improve their quality of life.

In person-centered planning, teams listen to and value the perspective of the person being supported. In person-centered planning, concerns about behaviors that limit access to the community might be addressed with the question, "What supports and activities need to be in place for her to ...go to a girl scout meeting ...get a job ...go to the movies ... live independently?" (Kansas Institute for Positive Behavior Support, 2012; University of Minnesota Positive Behavior Support Initiative, n.d.).

The person's voice and perspective are honored and the team supports and contributes to the vision of the person and the life he/she desires.

An effective person-centered plan should result in:

1. Increasing the person's involvement and participation in the community
2. Creating, developing, and enhancing meaningful relationships between the person and others
3. Expanding the opportunity for the person to express and make choices
4. Creating a dignified life and relationships based on mutual respect and need, and
5. Developing skills and areas of expertise for team members and the person that lead to improved quality of life (Kansas Institute for Positive Behavior Support, 2012; University of Minnesota Positive Behavior Support Initiative, n.d.)

Best practices in person-centered planning approaches include:

- a. Essential Lifestyle Planning: A planning process for learning how a person wants to live now and steps to establish that life. This process should be used when someone's life is in chaos or crisis, when it makes no sense to talk about dreams.
- b. Personal Futures Planning: A plan that emphasizes the future and involves getting to know a person, creating or recognizing a person's dreams, developing their ideas for their future, and taking action on those ideas. This process can be used when life is stable and the future needs to be sorted out.
- c. MAPS: A plan that helps people see where they are now, decide where they want to go, and how they can get there.
- d. PATH: A plan that is useful when a person has a group of people supporting them who are committed to making things happen. PATH plans empower people to understand and take control of the situation. Both PATH and MAPS can be used when there is some idea of the future and the present is stable or predictable.
- e. Person-Centered Thinking: A structured set of skills and tools for getting to know people and help them plan as well as a system for transforming an organization from system-centered to person centered.

A skilled person-centered planning facilitator will use tools from one or more of these approaches to customize the planning process for a person.

Person-centered planning is critical to the development of positive support plans because the goals of positive support plans are to increase quality of life and reduce the instances of challenging behavior. Person-centered planning ensures that a person defines his or her own quality of life.

Wraparound planning is an alternative to person-centered planning sometimes used with children and young adults with emotional and behavioral disorders. Wraparound planning emphasizes: Community based support; culturally relevant interventions individualized to a youth's strengths, preferences, and needs; and family-centered planning that empowers both the youth and his/her family. As with person-centered planning, Wraparound plans address life domains including living environments, basic needs, safety issues, social and emotional needs, educational aspirations, spiritual growth, and cultural values (Eber, 2011).

Both person-centered and wraparound planning are similar strategies that focus on improving quality of life, empowering persons and their families, and improving service coordination. Person-centered planning is more commonly used within the developmental disability field while wraparound planning is often associated with mental health and service coordination efforts for youth with emotional and behavioral disabilities. Both practices are used in a variety of settings. (Kansas Institute for Positive Behavior Support, 2012). Training with organizations like the Kansas Institute for Positive Behavior Support (KIPBS) encourages professionals to use the types of strategies that are the best fit for the characteristics and needs of the persons, their families, and the teams with whom they work.

BOTH PERSON-CENTERED AND WRAPAROUND PLANNING ARE SIMILAR STRATEGIES THAT FOCUS ON IMPROVING QUALITY OF LIFE, EMPOWERING PERSONS AND THEIR FAMILIES, AND IMPROVING SERVICE COORDINATION.

For more information on person-centered planning, see [Appendix C: The Art of Authentic Person-Centered Planning on page 31](#).

Part 4:

Positive Supports Strategies

The Rule 40 Advisory Committee recommended that all services and plans be positive, focus on improving a person's quality of life, and include building skills to achieve their desired life – not just focus on alleviating target symptoms or behavior. In their recommendations, the Rule 40 Advisory Committee recommended positive support strategies to apply to the multiple populations now covered under Minn. Statute §245D.

Often procedures to address problem behavior involve the delivery of consequences for problem behavior without considering how these interventions might affect other areas of an person's life. A single intervention, implemented to reduce problem behavior results in a narrowly-focused behavior plan that fails to consider establishing functional alternatives to the problem behavior and/or changes in the environment that may decrease the person's need to engage in problem behavior.

“Positive support strategies” focus on a combination of environmental changes along with support to enhance a person's self-regulatory skills and socially acceptable communicative and social alternatives to the purpose served by a person's challenging behavior. It also entails ensuring that desirable behavior is contingently reinforced while the source of reinforcement for problem behavior is removed.

To be successful, the selection of individualized positive support strategies must be based on the outcomes of a functional behavior assessment to determine the function (or outcome) that maintains the person's problem behavior. For example, some persons may gain escape from or postponement of activities that they find undesirable. Others may find that engaging in problem behavior often results in obtaining or maintaining attention. Still others may find that engaging in problem behavior often results in more quickly gaining access to desirable goods or services. ***The package of positive supports chosen must directly address the function or purpose of the problem behavior if the strategies chosen are to be maximally effective.***

Implementing a Functional Behavior Assessment to identify the events that trigger and reinforce problem behavior involves information gathering through record reviews, interviews, direct observation, and directly manipulating aspects of the environment to carefully evaluate their effect on the person's probability of producing problem behavior. At the conclusion of a functional behavior assessment team members serving the person must develop of summary statements. These summary statements describe the relationship between antecedent events, consequences delivered and the occurrence of problem behavior.

Primary outcomes of the functional assessment process include:

1. A clear description of the problem behaviors
2. Events, times, and situations that predict when behaviors will and will not occur (i.e., setting events)
3. Consequences that maintain the problem behaviors (function)
4. Summary statements or hypotheses
5. Direct observation data to support the hypotheses

For more information on Functional Behavior Assessment, see [Appendix D: Methods of Functional Behavioral Assessment](#).

Requirements for implementation of comprehensive intensive support services in [Minn. Stat. §245D.071](#) include:

1. Developing a preliminary coordinated service and support plan that is person-centered,
2. Developing and documenting service outcomes and supports based on assessments including a Functional Behavior Assessment when applicable, and
3. Ongoing progress reviews with the person and their legal representative and case manager

There is growing evidence that positive support strategies are effective with a wide range of populations including persons with mental health issues as well as those with disabilities such as dementia or traumatic brain injury (Association for Positive Behavior Support, n.d.) The Association of Positive Behavior Supports has information about how Positive Behavior Supports is being implemented in different communities. To view that information go to [Positive Behavior Support Information](#).

Positive support strategies are considered effective when interventions result in the person's increased success and the enhancement of their positive social behavior in the range of environments in which s/he participates (e.g. work, academic, recreational, and community settings). Valued outcomes include increases in quality of life as defined by an person's unique preferences and needs, and positive lifestyle changes that increase social belonging (University of Minnesota Positive Behavior Support Initiative, n.d.).

Developing and implementing Positive Supports involves careful assessment, intervention planning, intervention implementing, and performance monitoring. It also requires that the support team serving the person be prepared to engage in troubleshooting when problems arise.

The Association of Positive Behavior Supports had developed fact sheets on Positive Behavior Support Practices that include:

- a. Methods of Functional Behavioral Assessment (FBA)
- b. Collaborative Teaming in Positive Behavior Supports
- c. Proactive Support Strategies
- d. Positive Consequence Strategies
- e. Teaching Replacement Skills
- f. Systems Change in Positive Behavior Support
- g. Competing Behavior Model
- h. Group Action Planning and Positive Behavior Supports
- i. Addressing Cultural and Economic Diversity in Positive Behavior Supports

Person-centered planning, whenever possible, should be implemented before the creation of a Positive Behavior Support plan for two primary reasons:

1. If implementing a person-centered plan eliminates problem behavior and supports the emergence of desirable behavior, more comprehensive interventions are not needed.
2. If more comprehensive supports are required, a person-centered plan creates a framework for Functional Behavior Assessment and the development of a Positive Behavior Support plan (Kansas Institute for Positive Behavior Support, 2012; University of Minnesota Positive Behavior Support Initiative, n.d.).

Positive Behavior Support plans involve consideration of the broad contextual view of a person's life as well as the discrete environmental events that trigger and reinforce problem behavior.

Part 5: Sample Positive Support Transition Plan

Part A. Background Information

Name: Robert M.	PMI:	Projected Implemented Date: 2/1/14	Projected Ending Date (If including a prohibited procedure, must be no later than 11 months after implementation date): 12/31/14
Primary/Secondary Diagnosis: Anxiety, Obsessive Compulsive Disorder			
Frequency of Reviews: <input type="radio"/> Weekly <input checked="" type="radio"/> Monthly <input type="radio"/> Quarterly <input type="radio"/> Other		Date when Positive Support Transition Plan was written: 1/15/14	Date(s) Plan updated:
Service(s) and treatment provider(s) involved in implementation of plan: Person-centered planning by group home staff and Robert's family. Adjusted staffing time by group home staff.			

Prescribed psychotropic Medication(s)

Medication	Intake frequency	PRN? (as needed)
Zoloft 50 mg	once daily	<input type="radio"/> Yes <input type="radio"/> No
Xanax .5 mg	twice daily	<input type="radio"/> Yes <input type="radio"/> No
		Add medication

Part B. Target Interventions

Target Intervention(s) targeted for elimination

(e.g. Emergency Use of Manual restraints (EUMR), mechanical restraints, seclusion, etc.)

Intervention	Comments
Time out/removal to bedroom	
Add target intervention	

Objective Data Collection of Target Interventions

How will you measure each Target Intervention throughout the course of this plan?

Examples of methods would be: Frequency count | Duration recording | Time sampling | Interval recording | Permanent products | Rating scale

Intervention	Method	Comments

Desired, alternative, positive support strategy/intervention(s)

**Adjust approach for Robert to get ready to go to work in the morning.
Adjust schedule to allow him more time to get ready and to relax before his ride comes.**

Positive support strategy objective(s), including measurable criteria
(how will the intervention benefit the person)

Staffing has not allowed for flexibility in the morning schedule. We will allow 20 minutes of additional staff time on Robert's work days to allow him to get up earlier and have more time to get ready.

Baseline data (Number of targeted intervention(s) over at least two weeks of baseline data. If unable to acquire, document reasons)

In last two weeks, Robert was unable to get to work on Metro Mobility 3 times because he was not ready. Staff then had to drive him and he was late all three days. This tends to happen once a week or more.

Alternative Interventions that have been attempted, considered, and rejected as not being effective or feasible:

Use of an alarm clock to get him out of bed completely independently—Robert does not do well getting up when there is no staff around. He had a bad experience in another home five years ago.

Part C. Target Behaviors

Target Behavior(s), targeted for elimination defined in measurable and observable terms, identified for elimination

Behavior	Comments
Robert takes about 45 minutes to get ready for work. When he takes longer, his routine is disrupted and then he gets anxious and can't stay on task.	Robert's agitation ramps up and he cannot get back to his routine without de-escalating for several minutes. His anxiety is contagious and it makes his roommate agitated.

Objective Data Collection of Target Behaviors

Examples of methods would be: Frequency count | Duration recording | Time sampling | Interval recording | Permanent products | Rating scale

Behavior	Method	Comments

Desired alternative action(s)

Robert stays on task even when running late.

Identified/hypothesized purpose of the Target Behavior(s)

Robert wants his routine in the morning to be free of disruptions. He also desires to be on time for work. His response is his desire to let staff know that his routine is disrupted and he won't be ready on time.

Baseline data (pretreatment measurement of Target Behaviors) *submit at least two weeks of baseline data, or if unable to acquire, document reasons.*

In last two weeks, Robert was unable to get to work on Metro Mobility 3 times because he was not ready. Staff then had to drive him and he was late all three days. This tends to happen one a week or more.

Reported and/or observed impact the Target Behavior(s) have on the person's quality of life

It takes Robert anywhere from 20 to 30 minutes to decompress after one of these events. It also can disrupt his roommate's routine and causes a staff to drive him to work late.

Part D. Crisis Support Planning and Response

Phase I Calm/Ideal

Description of the person's affect/behavior when in phase I:

Robert loves his job and when he has enough time, he is happy to get ready.

Strategies/methods used to support the person maintain phase I:
(Include use of Psychotropic Medication, counseling, emotional regulation training, skill building, preferred activities, etc.)

Until recently, day staff comes in at 7:30 am and wakes him up right away. Most mornings, this is adequate but occasionally, not quite enough time. Night staff leaves at 1:00 am.

Phase II Triggers

Description of identified triggers/antecedents for the person:
(Situations, words, people, internal stimulus, decisions, critical periods, etc.)

Robert makes his own lunch and gets dressed independently. If one of these tasks takes too long (like if he can't find his lunch bag), he may perseverate and get stuck in the process.

Methods to support the person to cope with or avoid triggers/antecedents – proactive strategies: *(Proactive strategies = strategies to use before a known trigger/antecedent will be encountered)*

Get as many things organized the night before. If he is tired or has been out, he might forget to do this.

Methods to support the person when encountering triggers/antecedents – reactive strategies: (*Reactive strategies = strategies to use after encountering a trigger/antecedent*)

Robert can ask staff for assistance if he gets behind in his routine.

Phase III Escalation

Description of the person's affect/behavior when in phase III:

Robert gets agitated and begins pacing. Can become very vocal and loud; will not listen to staff.

Support/intervention strategies during phase III (Specific de-escalation techniques, offer PRN, call a crisis line, etc.)

Typically, staff will lead him back to his room and he will calm down after 10 to 30 minutes. He is safe in his room but the time is non-productive.

Phase IV Crisis

Description of the person's affect/behavior when in phase IV:

Robert gets agitated and begins to repeat "I can't be late again" over and over. He also gets louder the longer it goes on. One of his housemates get panicked after about 5 minutes of this (they ride on the same bus).

Intervention methods during phase IV (*Call 911, emergency use of manual restraint, etc.*)

Due to the set-up of the home, the only workable solution has been to move Robert to his bedroom so he can de-escalate without disturbing his housemates. There is only one staff on duty and she cannot get the others ready and support Robert.

Phase V Recovery

Description of the person's affect/behavior when in phase V:

After the others leave for work, Robert calms down and returns to his routine.

Strategies/methods to support the person in recovery phase (*Debriefing, personal stories, talking to an ally, etc.*)

Staff then take him to work. He doesn't like to be late so this is helpful but not his favorite.

Part E. Quality of Life

Quality of Life Indicator(s) (*minimum of two indicators, each from different categories*):

Indicator	Comments
Engagement in preferred activities	
Increased independence/living skills	

Objective Data Collection of Quality of Life Indicators Examples of methods would be: Frequency count | Duration recording | Time sampling | Interval recording | Permanent products | Rating scale

Indicator	Method	Comments
Robert will complete morning routine and have time to relax before his bus pick up five out of five days a week.		
Robert will complete morning routine independently (but have staff support when needed) five out of five days a week.		

Baseline for Quality of Life Indicator(s) *Minimum two weeks of data, or if unable to acquire, document reasons:*

See Data Collection below.

Part F. Authorship and Consent

NAME OF AUTHOR OF PLAN John Provider	POSITION/TITLE Behavior Analyst
DESIGNATED COORDINATOR OR AUTHOR'S SIGNATURE DATE	

Statement of Understanding and Consent

By signing this document, I am consenting to the interventions described in this plan. Consent can be withdrawn at any time and will automatically expire 365 days after signing below. Future, substantial changes to the plan will require consent before implementation.

NAME OF PERSON RECEIVING SERVICES OR LEGAL REPRESENTATIVE	SIGNATURE OF PERSON RECEIVING SERVICES OR LEGAL REPRESENTATIVE DATE	DATE
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Appendix A: Resources

National

[Association of Positive Behavior Supports \(APBS\)](#) provides information and training in positive behavior supports across various age groups, populations (children, developmental disabilities, mental health, brain injury) and settings (schools, family, and community organizations). APBS provides presentations and webinars in topics related to PBS, as well as in-depth standards of practice.

[The Cochrane Collaboration](#) is an international not-for-profit and independent organization, dedicated to making up-to-date, accurate information about the effects of healthcare readily available worldwide. It produces and disseminates systematic reviews of healthcare interventions and promotes the search for evidence in the form of clinical trials and other studies of interventions.

[Kansas Institute for Positive Behavior Support \(KIPBS\)](#) delivers training in positive behavior supports (PBS) and person-centered and wraparound planning. Online webinars are available, as well as research presentations in evidence-based practices.

[Massachusetts Department of Mental Health Restraint/Seclusion Reduction Initiative](#) provides technical assistance and policy resources for children, adolescents, and adults in the mental health system. The RSRI offers safety tool assessments and an extensive resource guide in providing supports.

[National Registry of Evidence-based Programs and Practices \(NREPP\)](#) is a searchable online registry of 341 interventions that support mental health promotion, substance abuse prevention, and mental health and substance abuse treatment. All interventions that are included in NREPP have been voluntarily submitted, have met a set of minimum requirements, and have been assessed by independent reviewers.

[Oregon Technical Assistance Cooperative \(OTAC\)](#) offers training in positive behavior supports for various populations, including the mental health community and autism spectrum disorder. Additionally, the Growing Resources Oregon (GRO) manual provides a comprehensive training for staff in person-centered approaches and positive behavior supports (PBS).

[Positive Behavior Supports Kansas \(PBS – Kansas\)](#) provides information on positive behavior supports throughout various service systems (school, mental health, developmental disability). PBS – Kansas also provides links to the latest research in evidence-based practices in PBS.

[Temple University Collaborative on Community Inclusion of Persons with Psychiatric Disabilities](#) is a research and training center dedicated to people with psychiatric disabilities participating fully in community life. Temple University Collaborative provides training, technical assistance, and best practices resources in various areas of community life. Numerous toolkits and publications are available in topics such as cultural competence, community integration, and self-determination.

Minnesota

Minnesota Children’s Mental Health Division Evidence-Based Practices Database was developed by DHS to guide decisions by parents and providers in planning for child and adolescent care. This tool is the first of its kind to be used in practice to address the question of what works for whom under what conditions. It incorporates data collected from rigorous review of scientific literature that suggest different techniques or strategies for treating children with various mental health disorders.

Wellness Recovery Action Plan (WRAP®) training is available through the Mental Health Consumer/Survivor Network. WRAP® is an evidence-based program to obtain and maintain wellness developed by Mary Ellen Copeland of the Copeland Center. WRAP® provides participants the chance to explore their own personal recovery goals and develop strategies to:

- a. Promote higher levels of wellness, stability and quality of life;
- b. Decrease the need for costly, invasive therapies;
- c. Decrease the incidence of severe symptoms;
- d. Decrease traumatic life events caused by severe symptoms;
- e. Increase understanding of these disorders and decrease stigma;
- f. Raise participants’ level of hope and encourage their actively working toward wellness;
- g. Increase participants’ sense of personal responsibility and empowerment.

Minnesota’s Adult Mental Health Resource Guide: Hope for Recovery is published by the National Alliance on Mental Illness (NAMI) Minnesota. This is a resource booklet for navigating the mental health system in Minnesota.

Minnesota Brain Injury Alliance Consumer Guide is an online guide with information to assist in making informed decisions about the quality of life following brain injury.

Minnesota/North Dakota Affiliate of the Alzheimer’s Association has been providing services, information, and advocacy for more than 30 years to people with dementia, their families and health care providers. Their mission is to eliminate Alzheimer’s disease through the advancement of research; to provide and enhance care and support for all affected; and to reduce the risk of dementia through the promotion of brain health.

Community Workbook on Evidence-Based Prevention was published by the Minnesota Department of Human Services Alcohol and Drug Abuse Division. It was created by Minnesota’s Evidence-based Practices Workgroup (EBPW) to help local communities and prevention professionals answer some of the most common questions that arise about evidence-based programming.

Person Centered Thinking and Planning Training are two 2-day interactive trainings available through the Minnesota Department of Human Services in partnership with the University of Minnesota’s RTC on Community Living. Person-centered planning is changing the culture of service planning. The person is the primary focus when using person-centered planning, not the disability, service or some other issue. The 2-day Person-centered thinking training serves as a foundation for everyone who is involved in supporting people with disabilities. The 2-day Person-centered planning training goes into more depth on the planning process to support person-centered approaches. Person-Centered Thinking is a pre-requisite for the Person-Centered Planning training.

Other State Policies

Arizona Department of Economic Security, Division of Developmental Disabilities **Policy and Procedures Manual, Chapter 1600 – Managing Inappropriate Behaviors**

This manual informs service providers of persons with developmental disabilities of the policies and procedures for behavioral interventions. This manual outlines permitted and prohibited techniques, staff training guidelines, and monitoring and oversight procedures.

Georgia Department of Behavioral Health and Developmental Disabilities **Guidelines for Supporting Adults with Challenging Behaviors in Community Settings**

This document offers information in positive behavior supports for persons with mental illness and persons with developmental disabilities. The manual outlines steps and provides comprehensive examples for positive support practices.

Michigan Department of Community Health, Mental Health & Substance Abuse Administration

Person-Centered Planning Policy and Practice Guidelines

This manual offers best practices for Michigan's service providers in person-centered planning for the developmental disability and mental health communities. It outlines person-centered planning as a basis for effective services and Positive Behavior Supports.

Vermont Department of Disabilities, Division of Disability and Aging Services

Behavior Support Guidelines for Support Workers Paid with Developmental Services Funds

This is a policies and procedures manual for service providers and support staff of persons with developmental disabilities. The manual offers guidelines for person-centered planning and positive behavior supports, outlines prohibited procedures, and provides information on completing a functional assessment.

Washington State Department of Social and Health Services

Developmental Disabilities Administration Policy Manual: **Positive Behavior Support/Policy 5.14**

This manual outlines policies of positive behavior supports for those with developmental disabilities and mental illness. It provides the components of a positive behavior supports and the elements of a functional assessment.

Appendix B:

Psychotherapies with an Evidence Base

Adapted from the [National Institute on Mental Health](#)

Psychotherapy, or “talk therapy”, is a way to treat people with a mental disorder by helping them understand their illness. It also can help patients manage their symptoms better and function at their best in everyday life.

Sometimes psychotherapy alone may be the best treatment for a person, depending on the illness and its severity. Other times, psychotherapy is combined with medications. Therapists work with an person or families to devise an appropriate treatment plan.

There is no “one-size-fits-all” approach. Some therapies have been scientifically tested more than others. Some people may have a treatment plan that includes only one type of psychotherapy. Others receive treatment that includes elements of several different types. The kind of psychotherapy a person receives depends on his or her needs.

These are some of the more commonly used therapies:

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is a blend of two therapies: cognitive therapy (CT) and behavioral therapy. CT focuses on a person’s thoughts and beliefs, and how they influence a person’s mood and actions, and aims to change a person’s thinking to be more adaptive and healthy. Behavioral therapy focuses on a person’s actions and aims to change behavior patterns.

CBT helps a person focus on his or her current problems and how to solve them. Both patient and therapist need to be actively involved in this process. The therapist helps the patient learn how to identify distorted or unhelpful thinking patterns, recognize and change inaccurate beliefs, relate to others in more positive ways, and change behaviors accordingly.

Dialectical Behavior Therapy

Dialectical behavior therapy (DBT), a form of CBT, was developed to treat people with suicidal thoughts and actions. The term “dialectical” refers to a philosophic exercise in which two opposing views are discussed until a logical blending or balance of the two extremes—the middle way—is found. In keeping with that philosophy, the therapist assures the patient that the patient’s behavior and feelings are valid and understandable. At the same time, the therapist coaches the patient to understand that it is his or her personal responsibility to change disruptive behavior.

Interpersonal Therapy

Interpersonal therapy (IPT) is most often used on a one-on-one basis to treat depression or dysthymia (a more persistent but less severe form of depression). IPT is based on the idea that improving communication patterns and the ways people relate to others will effectively treat depression. IPT helps identify how a person interacts with other people. When a behavior is causing problems, IPT guides the person to change the behavior. IPT explores major issues that may add to a person's depression, such as grief, or times of upheaval or transition. Sometimes IPT is used along with antidepressant medications.

Family-Focused Therapy

Family-focused therapy (FFT) was developed for treating bipolar disorder. It was designed with the assumption that a patient's relationship with his or her family is vital to the success of managing the illness. FFT includes family members in therapy sessions to improve family relationships, which may support better treatment results.

Therapists trained in FFT work to identify difficulties and conflicts among family members that may be worsening the patient's illness. Therapy is meant to help members find more effective ways to resolve those difficulties. The therapist educates family members about their loved one's disorder, its symptoms and course, and how to help their relative manage it more effectively. When families learn about the disorder, they may be able to spot early signs of a relapse and create an action plan that involves all family members. During therapy, the therapist will help family members recognize when they express unhelpful criticism or hostility toward their relative with bipolar disorder. The therapist will teach family members how to communicate negative emotions in a better way.

Psychodynamic Therapy

Historically, psychodynamic therapy was tied to the principles of psychoanalytic theory, which asserts that a person's behavior is affected by his or her unconscious mind and past experiences. Now therapists who use psychodynamic therapy rarely include psychoanalytic methods. Rather, psychodynamic therapy helps people gain greater self-awareness and understanding about their own actions. It helps patients identify and explore how their non-conscious emotions and motivations can influence their behavior. Sometimes ideas from psychodynamic therapy are interwoven with other types of therapy, like CBT or IPT, to treat various types of mental disorders.

Light Therapy

Light therapy is used to treat seasonal affective disorder (SAD), a form of depression that usually occurs during the autumn and winter months, when the amount of natural sunlight decreases. Scientists think SAD occurs in some people when their bodies' daily rhythms are upset by short days and long nights. Research has found that the hormone melatonin is affected by this seasonal change. Melatonin normally works to regulate the body's rhythms and responses to light and dark. During light therapy, a person sits in front of a "light box" for periods of time, usually in the morning. The box emits a full spectrum light, and sitting in front of it appears to help reset the body's daily rhythms.

Expressive or Creative Arts Therapy

Expressive or creative arts therapy is based on the idea that people can help heal themselves through art, music, dance, writing, or other expressive acts.

Animal-Assisted Therapy

Working with animals, such as horses, dogs, or cats, may help some people cope with trauma, develop empathy, and encourage better communication. Companion animals are sometimes introduced in hospitals, psychiatric wards, nursing homes, and other places where they may bring comfort and have a mild therapeutic effect. Animal-assisted therapy has also been used as an added therapy for children with mental disorders.

Preview Only

Appendix C:

The Art of Authentic Person-Centered Planning

Adapted from [the Council on Quality and Leadership](#)

Engaging in authentic Person-Centered Planning is fun, creative and synergistic work. This life planning process is rooted in what is most important to the person and involves the person directly with his or her community, network of connections, and close personal relationships to look at innovative ways to attain life goals and dreams.

The greatest reward in engaging in this process as a supporter is being able to witness a transformation occurring in a person's life when creative new directions and approaches are taken. To a person who has been supported in this process, there is nothing better than having a circle of collaborative supporters fully engaged with him or her as he or she moves towards the realization of specific life dreams and into a world of greater possibility for new goals to emerge.

Authentic Person-Centered Planning-What it is

Authentic Person-Centered Planning processes have a number of common elements:

- a. The focus is entirely on the person, never the system.
- b. Numerous mainstream resources are unearthed, considered, researched and used. These resources are the ones that would be tapped first and foremost. For example, local community/neighborhood linkages, social programs, and assets; foundation grants; Community Development Block Grants; income generating ideas (jobs, micro-enterprise, self-employment); resources available from the person's place of worship; free cell/mobile phone programs; state and local housing programs; utility company discounts; extended family resources, if any; local business grants and collaboration; and many others.
- c. System resources are considered after the person's dreams, interests and gifts have been discovered and only in relationship to how those resources can be used to support people in achieving their dreams and contributing their gifts.
- d. System resources are not used to determine if something is feasible or can be reimbursed or as an approval or denial process.
- e. The process asks "How can we do this?" rather than finding reasons why we can't.
- f. The process and participation in the process depend more on our heart connections with the person than on our professional connections to the person.
- g. People are invited to attend by the person using services (as opposed to required).
- h. Many of the people attending are not paid to be there and might include neighbors, co-workers, friends, family, and community members from various affiliations.
- i. The group usually meets on some kind of regular basis to connect and follow-up and keep the energy and momentum moving forward. Perhaps weekly or bi-weekly to start.

- j. The space is usually not a conference room. Living rooms, church social halls or private rooms in restaurants are good choices. There is usually food to share and gatherings often occur at times other than Monday-Friday between 9:00 am and 5:00 pm.
- k. Notes are usually taken on big pieces of paper with colored markers, or pastels and chalks, often with images instead of words.
- l. Wacky ideas are often considered – and the rules of creative brainstorming are embraced.
- m. Not every dream and idea that is generated will become the ones that happen - the person's foremost priorities, dreams, and preferences become the focus of action.
- n. There is no checked-off documentation that has to be turned in somewhere.
- o. Lives are transformed through an authentic Person-Centered Planning Process.
- p. When and if a second Person-Centered Plan is completed, it will not look or feel anything like the first one, as the person's life will have changed and there will be new opportunities and challenges to explore.

Authentic Person-Centered Planning-What it is not

- a. These examples indicate “Systems-Centered” not Person-Centered Planning:
- b. A case manager, service coordinator, and/or another professional who called and facilitated the meeting and services are the main focus vs. the person.
- c. The majority of (or all) attendees are paid professionals with titles. The meeting takes place annually in a meeting or conference room.
- d. Assessments are done ahead of time by titled professionals with recommendations.
- e. The meeting lasts for one or two hours, and forms and documentation are circulated and signed off on during that time.
- f. Programs, services and hours are the primary discussion, not a person's life dreams.
- g. Everything “wrong” with the person is pointed out and discussed.
- h. The person is nervous, uncomfortable, doesn't participate or is not present. Afterwards the documentation is filed away – every person served has one of these standard documents with their name on it in the official “case” file.

Engaging in authentic Person-Centered Planning vs. Systems-Centered Planning can be truly transformational to the person and supporters involved. This type of process can create major positive life changes for an person. It is an enjoyable and collaborative endeavor that can reap amazing rewards because it doesn't rely on a system to make change happen. Instead, it creates increasing opportunities for a person to be included in their local communities as a reciprocating member. The person's social capital (the value of one's networks), inclusion, and capacity grows leaps and bounds when his or her identification is with community, neighbors, friends and loved ones vs. a system of services.

Appendix D: Methods of Functional Behavioral Assessment

Adapted from the [Rehabilitation, Research and Technical Center on Positive Behavior Support](#)

Functional behavioral assessment (FBA) is a systematic process for gathering information to determine the relationships between a person’s problem behavior and aspects of their environment. Through FBA, it is possible to identify specific events that predict and maintain behavior and design a support plan that effectively addresses those variables. FBA methods can, and should, vary across circumstances, but typically include record reviews, interviews, and direct observation.

Method	Sample Sources/Tools	Examples/Products
Record Reviews	Diagnostic/ Medical records, psychological reports, assessments from therapies, developmental profiles, social histories, previous behavior management plans, IEPs, ISPs, anecdotal records, incident reports, discipline referrals	Sammy’s records contained: History of allergies and asthma, some effective educational strategies used in the past, and patterns of discipline referrals
Structured Interviews	People who know the person well and represent a range of environments (the person, family members, teachers, friends, direct service providers, etc.) may be interviewed.	Interviews of Delores’ family, friends, and job coach addressed her preferences for “low key” settings, difficulty with dramatic changes in routine, and beliefs that she is motivated to avoid demanding social circumstances
Direct Observation	Observations should be conducted across a variety of times and circumstances.	Scatterplot data indicates that Ben’s biting is most likely when he is getting ready to leave in the morning and immediately after lunch

FBA methods range from highly precise and systematic to relatively informal. Particular tools and strategies should be selected based on the circumstances, persons involved, and goals of intervention.

The goal of FBA, regardless of which methods are used, is to answer certain questions:

1. Under what circumstances is the behavior most/least likely to occur (e.g., when, where, with whom)?
2. What outcomes do the behavior produce (i.e., what does the person get or avoid through his or her behavior—quality and quantity of reinforcer)?
3. What is the frequency of the behavior?

To answer these questions, the information gathered must be analyzed and summarized. Hypothesis (or summary) statements describe the specific patterns identified through the FBA and, if supported by the data, provide a foundation for intervention. A hypothesis statement must describe the behavior and surrounding conditions, and be clear, comprehensive, and unbiased to be useful. Example: “When Steven finishes his work early, he makes noises and destroys his materials. His behavior prompts his supervisor to initiate an alternative activity.”

Frequently Asked Questions

1. *When and why should a functional behavioral assessment be completed?*

An FBA may be initiated when a person’s behavior interferes with performance, progress, and/or participation within typical daily routines and environments. It is completed for the purpose of designing an effective intervention that will allow the person with challenging behavior to be successful across all circumstances.

2. *Who should do a functional behavioral assessment (e.g., what qualifications are needed)?*

It is important to have people who are experienced and skilled in FBA, competent in promoting collaboration, and proficient in designing effective positive behavioral support strategies involved in the process. Such people may come from varying backgrounds. (e.g., applied behavior analysis, school psychology).

3. *What is the difference between functional behavioral assessment and functional analysis?*

Functional behavioral assessment is a broad term referring to the information gathering and hypothesis development process. It can involve a variety of methods, including functional analysis. Functional analysis is a rigorous experimental procedure in which hypotheses are tested by manipulating antecedents and consequences to see what impact they have on behavior. Whereas functional analysis may be useful in some circumstances, this is not always necessary or appropriate.

Appendix E: Links to DHS Documents and Forms

Behavior Intervention Reporting Form

<https://edocs.dhs.state.mn.us/lfserver/Secure/DHS-5148-ENG>

Positive Support Transition Plan

<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810-ENG>

Positive Support Transition Plan Review

<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810A-ENG>

Instructions for Completing Positive Support Transition Plan

<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6810B-ENG>

Jensen Settlement

http://mn.gov/web/prod/static/mnddc/live/meto_settlement/documents/METO_Settlement_Agreement_6-23-11.pdf

Minnesota Olmstead Plan

http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/dhs16_180147.pdf

Minnesota Statute 245D

<https://www.revisor.mn.gov/statutes/?id=245D&format=pdf>

Protection Standards

<https://www.revisor.mn.gov/statutes/?id=245D.06>

Rule 40 Advisory Committee: Recommendations on Best Practices
& Modernization of Rule 40

<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6748-ENG>

Minnesota Administrative Rules 9525.2700 to 9525.2810 (formerly known as Rule 40)

<https://www.revisor.mn.gov/rules/?id=9525.2700>

Sample Policies and Forms for Basic Supports and Services

http://www.dhs.state.mn.us/main/groups/licensing/documents/pub/dhs16_177363.pdf

Sample Policies and Forms for Intensive Supports and Services

http://www.dhs.state.mn.us/main/groups/licensing/documents/pub/dhs16_180212.pdf

Appendix F: References

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