Standard Clinical Practice: Dangerous Behaviors

Dangerous behavior definition: Dangerous behaviors are a subset of maladaptive or problem behaviors. Dangerous behaviors are severe behaviors that could result in physical injury requiring first aid or medical attention, or behaviors that could result in law enforcement involvement. Dangerous behaviors often require significant environmental or personal accommodations be made in order to keep the individual or others safe. Examples of this are wearing a helmet to prevent injury from head banging, removing all sharp objects from the house or installing multiple locks on doors.

Dangerous behaviors **do not** include age-appropriate behaviors such as biting in a 3-year-old or siblings hitting each other with open hands not resulting in the need for first aid or medical attention. Dangerous behaviors include the following categories:

1. **Self-injurious behavior** that could result in the need for first aid or medical attention (e.g. biting or hitting head).
2. **Physical harm** to others that could result in the need for first aid or medical attention (hitting another person with a fist or biting another person).
3. **Dangerous elopement** that is not age-appropriate and could result in injury (e.g. a 12-year-old running into traffic).
4. **Sexually inappropriate behavior** that could result in physical harm, serious complaint from others or law enforcement involvement.
5. **Property destruction** that could result in law enforcement involvement.
6. **Eating food or non-food items** that is not age-appropriate and could result in medical attention.
7. **Behaviors connected to elimination** that could result in physical harm or are severely socially inappropriate.
8. **Other behaviors** that might lead to physical harm or lead to law enforcement involvement.

When dangerous behaviors are present, Providers must indicate the type of dangerous behavior(s) in the report template. These should be done for all reports. Documentation must also include date or age of onset of the behavior, frequency and severity of the behavior. Report templates include dropdowns for this information. If at any time a new dangerous behavior occurs, or previously documented dangerous behavior has worsened in severity or frequency, the Provider is required to submit a reportable event.

Physical Prompting and High-Risk Behaviors

There are two types of physical prompts: full physical and partial physical. Full physical prompting is hand-over-hand guidance needed to complete a skill, and partial physical prompting is providing some physical guidance (or touch) when needed to complete a skill. Prompting should begin with the least intrusive prompt necessary to evoke the correct response and prompts should be faded as soon as possible. Thus, physical prompts should only be used when visual, gesture, verbal, positional or other less

intrusive prompts do not evoke the correct response. Physical prompting should be faded to a less intrusive prompt immediately.

Physical prompting can cause problem behaviors to escalate. This may be particularly true for older children, youth and adults. Physical prompting should not be used when a client is exhibiting escalated high-risk behavior (behaviors that could become dangerous) or there is a reasonable expectation that physical prompting would be an antecedent for a dangerous behavior or escalate a dangerous behavior.

Blocking

Blocking is a method of inhibiting a behavior that is about to occur or is already in process. This procedure should only be used after reinforcement procedures have been exhausted with little to no change in behavior. For example, a child is about to put something in their mouth that is not edible, when the parent or other caregiver stops the behavior from finishing by placing their hand in between the child's mouth and their hand.

There are a number of considerations when deciding to implement a blocking procedure with a client, which include **age of client**, **size of the client, physical ability of the practitioner, function of behavior**, **severity of behavior** and **probability of occurrence of increase in other topographies of behavior** (e.g. aggression towards blocker).

When **not** to use blocking:

1. Clients age 12 and older.
2. Client is under 12 but is bigger than the practitioner.
3. When target behavior is attention maintained.
4. When the probability of utilizing a blocking procedure will escalate severe or dangerous behavior, **blocking is not recommended.** The exception to this guideline is when blocking is being used in an emergency situation to prevent injury. In this case, blocking can be used before physical restraints.

Consultation with BHPN BCBAs around the use of blocking is available.

Physical Restraints

A restraint is defined as the use of physical, mechanical or other means to temporarily subdue a client or otherwise limit their freedom of movement. Restraint is used only when other less restrictive measures have been found to be ineffective to protect the client or others from injury or self-harm.

De-escalation of behavior: Every attempt should be made to de-escalate the behavior before using physical restraints. Access to a preferred activity or item, ending

the session, enlisting caregivers, allowing the client to leave the area and acknowledging how the client is feeling can be used to try to de-escalate the behavior.

Restraints are to be used for dangerous behaviors only. It is never appropriate to use physical restraints for non-dangerous behaviors (e.g. hand flapping, non-compliance that is unlikely to result in a dangerous situation).

Risk to using physical restraints: There is always a risk of injury to a client, practitioner or others in the area when using physical restraints. This risk must always be weighed against the level of dangerous behavior. For example, stopping a client from running into traffic on a busy street is worth the risk of the client receiving a bruise from being restrained. Stopping a 12-year-old client from walking out the front door of a house when the client can be safely followed is not worth the risk of restraints. Practitioners must always take the possible consequences of physical restraints into account when deciding to use physical restraints.

Appropriate use of physical restraints: This should only occur in the event a client is in **imminent danger** of harm to themselves or others (see definition of dangerous behavior), and a practitioner must restrict the client to protect the safety of the client or others.

In the event a Provider identifies a need for restraints to be used with a BHPN client, the following must occur:

- Practitioners working with the client must be certified to conduct restraints.
- Client's treatment plan must be updated to reflect this intervention, and **submitted and approved by BHPN, prior to implementation of restraints. The treatment plan must include confirmation that all practitioners working with the client are certified in the use of restraints.** The only time physical restraint can be used without approval by the BHPN is in an emergency situation that could not have been predicted prior to the behavior happening. For example, a client who has not engaged in dangerous behavior in the past grabs a younger sibling by the neck. In this case the practitioner could use physical restraints to prevent physical injury to the sibling. A Reportable Events Form must be made following the incident and the BHPN and practitioner will discuss changes to the treatment plan required to respond to the new behavior.
- A CCM and BHPN BCBA will review all restraint plans.
- Client, or legal decision-maker, must consent to the use of restraints before they are implemented as part of a treatment plan.
- Each time a restraint is used, a debrief must occur with the client, family and staff.
- When physical restraints cannot be safely used, law enforcement should be called. For example, a 17-year-old male who has a history of

dangerous elopement runs out the door of his home, but the practitioner cannot stop the client without risking significant injury to himself, the practitioner or others; the client should be followed while 9-1-1 is called.

- The environment is an important factor in deciding if physical restraint should be used. If the environment (e.g. a room with lots of furniture) makes physical restraint too dangerous, attempts must be made to move the client to a safer environment.
- Upon a restraint being implemented, a **Reportable Event Form must be submitted** to the BHPN and should include the notes from the debrief(s).

Intentionally Evoking Behavior

There are situations when intentionally evoking a dangerous or potentially dangerous behavior is clinically indicated; however, this is rare and should only be done with extreme caution and prior consultation with the BHPN. Whenever possible, a caregiver video recording should be used as an alternative to observing the behavior directly in real-time through intentionally evoking the behavior. Intentionally evoking behavior is particularly risky in clients over the age of 5 and this risk intensifies with increasing age and size of clients. This risk includes the possibility of injury to the client, practitioner and others. **Parents/caregivers and, when appropriate, the client must consent to this intervention.**

Intentionally evoking behavior should only be done as part of a functional analysis (FA) <u>AND</u> must be approved ahead of time by the BHPN. The following considerations must be thought through:

1. Client's history of dangerous behavior.
2. Parent/caregiver or client consent.
3. Whether evoking the behavior during the FA can be done in a highly controlled and safe environment. Home environments are rarely controlled enough to safely evoke severe or potentially severe behavior in clients over the age of 5.