Ohio | Department of Mental Health

Hospital Services
Behavior Therapy Committee

Behavior Therapy Manual

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Recommendation for Approval:

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As referenced in Administrative Rule 5122-2-19
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Contents

Behavior Plans

"Behavior therapy" means the utilization of interventions in which positive reinforcers or regulated interventions (See p. 8) are applied in a systematic and contingent manner in the context of individual or group programs to change or manage behavior or facilitate improved self-control. The goal of behavior management is not to curtail or circumvent an individual's rights or human dignity, but rather to assist the individual in increasing his/her ability to exercise those rights. Prohibited actions may not be implemented under any circumstances (See p. 9).

"Behavior therapy plan/ behavior plan" means an agreement negotiated with the person served, and as appropriate, parent or guardian, in which mutually agreeable behavioral goals and interventions are specified.

1) **Only trained, qualified staff may implement behavioral therapy plans;**

2) **Individual behavior therapy plans:**
   a) Individual behavior plans are developed for a single individual. Individual behavior plans will be developed on the Behavior Plan Form. The form may be designed to be computer generated or used in connection with ODMH standard software. The patient will be actively involved in developing the plan. The plan focus will be proactive, positive, and will reflect the goals, interests, values, and choices of the patient.

   b) Individual behavior plans that include only Recommended Proactive Positive Interventions may be implemented when the Treatment Team approves them and they are signed. They must be immediately submitted to the Regional Psychiatric Hospital Behavior Therapy Committee (RPHBTC) for review and approval.

3) **Group behavior therapy plans:**
   a) Group behavior plans may use only recommended interventions and are developed for a unit or other group of patients. All members of the unit or group have the opportunity to participate. No member may be required to participate or have any negative consequence other than the inability to earn any reinforcement that might be earned by participating in the plan. Group contingencies are not based on the behavior of individual members.

   b) Group behavior plans will be developed on the Group Behavior Plan Form. Each plan must have a designated staff member responsible for ensuring that the plan is explained to all patients who are eligible to participate. There must be a procedure for this responsibility to be transferred to other staff when the responsible staff member is not present. Group behavior plans must be submitted to the RPHBTC for review and approval before they can be implemented.

4) **Documentation of behavioral therapy plans:**
   Behavioral interventions should be documented in a behavioral plan and be referred to in the Comprehensive Treatment Plan (CPT). Behavioral interventions should be documented on form DMH-BT-01 (attachment 1) or form DMH-BT-02 (attachment 2).

Behavior Therapy Interventions

Recommended Proactive Positive Interventions

Recommended proactive positive interventions are those that have maximum probability of benefiting patients, minimal risk of harm or negative consequences, and are consistent with enhancing the recovery process.

- **Anger Management**

  Interventions directed at understanding the physiological response of anger, expressing anger constructively, anticipating and managing situations that may provoke anger, and controlling the anger response.

- **Bio-feedback**

  Changing a physiological response that is not normally perceptible by measuring it, proving information on the level of the response and providing reinforcement when it is altered in the desired direction. (The feedback that the change is occurring may be sufficient reinforcement).

- **Booster sessions**

  Treatment sessions that occur at intervals after the termination of successful treatment to maintain the therapeutic gains.

- **Chaining**

  Behavior chain is a complex behavior consisting of two or more temporally sequential responses, each associated with a specific stimulus condition.
  Task analysis involves breaking down a behavior chain into its component responses; that is, complex tasks are broken down into small teachable units.
  Forward chaining, **backward chaining**, and **concurrent chaining** (also called **whole task or total task presentation**) are procedures commonly used to teach complex behaviors.

- **Cognitive Behavior Therapy**

  Cognitive-behavioral therapy is an action-oriented form of psychosocial therapy that assumes that maladaptive, or faulty, thinking patterns cause maladaptive behavior and "negative" emotions. (Maladaptive behavior is behavior that is counter-productive or interferes with everyday living.) The treatment focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. [Gale Encyclopedia of Medicine, Paula Ann Ford-Martin].

- **Dialectical Behavior Therapy**

  A complex program of cognitive and behavioral interventions, using a biosocial model, initially organized for treating para-suicidal gestures in Borderline Personality Disorder. DBT seeks to improve emotional regulation, interpersonal relating, distress tolerance, and mindfulness using various modalities depending on the treatment setting and functioning level of the participant. DBT usually involves some form of individual therapy, group skills training, telephone consultation with the therapist, and therapist feedback meetings. Outcomes vary depending on the

target behavior (self-injurious behavior, antisocial behavior, dually diagnosed [SAMI], or juvenile delinquency.) DBT requires specialized training and experience to implement.

- **Differential reinforcement of all types**

  Differential reinforcement of high rates of responding (DRH) is the reinforcement of responses higher than a predetermined criterion (i.e., in rapid succession at a preset rate).

  Differential reinforcement of diminishing rates of responding (DRD) is the reinforcement of responses gradually decreasing rates of a target behavior (e.g., reinforcing the behavior only if it occurs fewer than 4 times per hour; then no more than 3; etc.).

  Differential reinforcement of other behavior (DRO) is the delivery of reinforcers contingent on the nonoccurrence of a response for a given time interval, and the reinforcement of whichever other behavior is occurring at that time. This procedure is sometimes called **omission training** or **differential reinforcement of zero rates of responding**. Contingency is a dependent relationship between a response class and one or more stimulus classes (operant) or between two or more stimuli (respondent).

  Differential reinforcement of low rates of responding (DRL)is a schedule of reinforcement where reinforcement is delivered at the end of a specified time interval contingent on the occurrence of fewer than a specified number of responses.

  Differential reinforcement of alternative behavior (DRA) is the selection and reinforcement of specific behaviors that are appropriate alternatives to (but not incompatible with) a target behavior which, in turn, is not reinforced. It may be best to use functionally equivalent alternative behaviors which are topographically dissimilar to the target behavior. This procedure is sometimes called **Alt-R**.

  Differential reinforcement of incompatible behavior (DRI), also referred to as **differential reinforcement of alternative behavior (DRA) is** a schedule that delivers reinforcement contingent on the occurrence of a particular behavior that is defined as being incompatible with the target behavior.

- **Extinction**

  A consequence is withheld (operation), and as a result, some extent of occurrence of the response class is less likely to occur (effect).

- **Fading**

  A technique to gradually transfer stimulus control from prompts to other discriminative stimuli. Specific procedures to transfer stimulus control include most-to-least prompts (**fading out**), least-to-most prompts (**fading in**), **graduated guidance**, **time delay**, **stimulus fading**, and **stimulus shaping**.

- **Maintenance**

  Interventions designed to maintain a target behavior that has been achieved and to generalize it to other appropriate stimulus conditions.

- **Modeling**

  Models are antecedent stimuli which are topographically similar to the target imitative behavior. **Modeling** consists of presenting a model that sets the occasion for the imitative response, which is then reinforced. Modeling may be more effective when combined with other procedures such as instructions, prompting, rehearsal, and verbal feedback (reinforcement).

- **Positive reinforcement**

  A stimulus is presented after a response (operation), and as a result, the future frequency of the response class increases (effect).

  For interventions involving non-contingent positive reinforcement, the treatment team may review the target behaviors, indicate how the team will be working with the consumer to help learn the replacement behaviors, and give a general overview of the plan without providing the specific schedule and method for non-contingent positive reinforcement.

- **Prompting**

  Prompts are supplementary antecedent stimuli used to evoke a response in the presence of the discriminative stimuli which eventually will control the target behavior. Common types of prompts include **verbal**, **gestural**, **modeling**, and **tactual** or **physical**.
  (**Antecedent** is a stimulus that precedes a behavior in time.)

- **Quiet Time**

  A voluntary decision by a patient to remove himself/herself from an overly stimulating situation in order to maintain self control or replenish inner calm. A staff person may also initiate quiet time by suggesting that a patient use this procedure. A quiet room is an unlocked place where a patient chooses to take quiet time.

  Note: Quiet time can take place in a room, place, or space on the unit. A quiet room that is not locked is a place where quiet time may take place. A quiet room is a place that can be made available at the patient's request. The use of quiet time may be part of the comprehensive treatment plan and documented in the patient's records. A seclusion room may not be used for quiet time unless the advanced, written authorization of the RPHBTC has been obtained.

- **Relapse Prevention**

  Interventions designed to prevent the reoccurrence of a previously experienced behavior problem or mental illness.

- **Relaxation/Stress Management**

  Interventions in recognizing sources of stress, avoiding, minimizing, or managing stress, and relaxations techniques.

- **Sensory Interventions**
  Interventions designed to sooth an individual's emotional distress by focusing on treating the person's senses (e.g. aromatherapy).

- **Shaping**
  Shaping involves the differential reinforcement of successive approximations to a terminal target behavior. Shaping can be done across or within response topographies. The efficiency of shaping can be increased by using discriminative stimuli such as prompts.

- **Social Skills Training**
  Training in specific interpersonal behaviors that may include initiating conversations, appropriate topics for conversations, interpersonal space, selecting acquaintances, developing relationships, maintaining relationships, assertiveness, and interpersonal dining.

- **Systematic desensitization**
  Intervention to treat phobias or other anxiety provoking situations or stimuli by training in muscle relaxation, developing a hierarchy of anxiety provoking situations, and working through the hierarchy while practicing relaxation.

Regulated interventions

Regulated interventions are those which contain any procedures which are not positive. All regulated interventions must be a part of a behavior plan. The patient must agree to the behavior plan. Plans using regulated interventions must be approved by the RPHBTC and then immediately forwarded to the designated Ohio Legal Rights Service (OLRS) representative and to the HSBTC for review. Only upon approval by the HSBTC may the plan be implemented. Monthly reports of progress must be submitted to the RPHBTC. That committee will monitor the implementation and progress of the plan and require changes if needed to improve the plan or discontinue it. Monthly progress will also be reported to the HSBTC, which may require change or discontinuation if the plan is determined not to meet professional standards, not to be in the best interest of the patient, or not to be benefiting the patient.

- **Loss of access to room**
  Restricting access to the room where the individual sleeps and has his/her personal belongings.

- **Loss of valued items**
  Temporary loss of access to one or more valued items for a defined period of time. Permanently taking the personal property of any individual is prohibited under any circumstances.

- **Overcorrection and positive practice of less than 30 minutes**
  Overcorrection
  Having the individual restore the environment to a state that is beyond the damage caused by the behavior or engage in behavior that exceeds that necessary to correct any problem caused by the behavior.

Positive practice

Contingent upon a negative behavior, repeating a positive alternative to the negative behavior beyond the point that would be reasonably expected in learning the behavior.

- **Response cost**

  The contingent loss of reinforcers that have previously been earned.

- **Time out less than 30 minutes**

  Time out is the removal or decrease in the opportunity to obtain positive reinforcement. In this case, time out is a procedure where the individual is removed from the environment to a separate room or place until he or she exhibits behavior, "ready behavior", indicating control of his or her behavior for a defined period of time.

Prohibited Actions

Prohibited actions are those that may not be implemented under any circumstances and will lead to disciplinary action. The RPHBTC is responsible for ensuring that prohibited interventions are not implemented.

- **Electric Shock**

  The application of any stimulus involving electrical stimulation. Does not include Electroconvulsive Therapy (ECT).

- **Fear-eliciting procedures**

  An intervention designed to cause the individual to become frightened, fearful, or panicked. Procedures designed to treat phobias by controlled exposure to feared stimuli are permitted,

- **Locked Time out**

  Time out is the removal or decrease in the opportunity to obtain positive reinforcement. In this case, this is a procedure where the individual is removed from the environment to a separate room or place where egress is prohibited.

- **Loss of bed**

  Removal of the bed or denial of access to the bed at usual sleeping times. Being required to sleep on anything other than a normally provided bed. Does not apply to alternative sleeping items provided in seclusion or restraint rooms during procedures covered by the Administrative Rule on Seclusion and Restraint.

- **Loss of food/water**

  Loss of access to food/water that would otherwise be permitted contingent on a behavior not directly related to the use of food or water.

- **Noxious stimuli including noxious smells**

  The application of or exposure to any substance with an unpleasant taste, smell, or feel (e.g. use of water spray in the face of a patient)

- **Time out greater than 30 minutes**

  Time out is the removal or decrease in the opportunity to obtain positive reinforcement. In this case, this is a procedure where the individual is removed from the environment to a separate room or place.

- **Physical pain (hitting, spanking)**

  Any procedure intended or with a probability of inducing pain.

- **Procedures intended to embarrass**

  Any procedure designed to cause embarrassment, humiliation, or shame.

- **Seclusion or restraint as a behavior therapy intervention**

  "Restraint" means all items or measures used to limit or control the movement or normal functioning of any portion or all of a patient's body.

  "Seclusion" means confinement of a patient alone in a room, locked or unlocked, which that patient is physically prevented from leaving for any period of time.

Proactive Positive Intervention
Behavior Management Guidelines for Use by Staff

A distinction needs to be made between a Behavior Plan and Behavior Management Guidelines for Staff. When a patient requires behavior therapy services but refuses to consent to these services, then a formal behavior plan is not possible due to the absence of patient consent. In this type of circumstance, a psychologist may consult with the treatment team and provide proactive positive staff guidelines for working with the patient.

These guidelines, called **Behavior Management Guidelines for use by Staff**, could include:

- environmental modification,
- how staff should approach the patient,
- how staff should attempt to interact with the patient, and
- how staff should respond when the patient exhibits maladaptive behaviors.

A written Behavior Management Guideline for use by Staff can assist staff in treating the patient's maladaptive behavior with proactive positive interventions, in a therapeutic and consistent manner, without having the patient consent necessary for a formal Behavior Plan. Behavior Management Guidelines for Staff must include only Recommended Proactive Positive Interventions and may be implemented when the Treatment Team approves them. In addition, they must be immediately submitted to the RPH Behavior Therapy Committee for review and approval. The Treatment Team of the patient will need to ensure that continued efforts are made to build rapport and engage the patient in treatment or in developing a behavior plan with patient consent. It is important that these Behavior Management Guidelines for use by Staff be referenced in and included in the Comprehensive Treatment Plan.

Please refer to ODMH Document MD-19 for more information about Proactive Positive Interventions.

Development of Individual Behavior Therapy Plans

1. Staff person or patient identifies the need for a Behavior plan.

2. The need for Behavior plan is discussed in Treatment Team and the Team and patient agree that this is in the best interest of the patient's recovery. The Team and patient agree on the basic focus of the Behavior plan.

3. A staff person with expertise in writing Behavior plans takes primary responsibility to write the plan, in conjunction with the identified patient.

4. *The most recent version of the HSBTC approved Behavior plan form is used for* writing the plan (a copy of this form is in the Behavior Therapy Manual - see Attachment 1).

5. Identifying information at the top is the form is mostly self-explanatory. It is particularly important that the type of plan (recommended or regulated) is specified and that the treatment/recovery plan problem and plan title are also specified. The Behavior plan must be referenced in the patient's Comprehensive Treatment Plan (CPT) and be an addendum to the CPT.

6. The information placed in each section of the form is as follows:

   a. **Background Information/Previous Interventions/Rationale for Plan:** This section states why the plan is being written, what has already been tried, what the results of the previous interventions were, contextual factors and the rationale for the current strategy.

   b. **Target Behavior(s):** *The behavior(s) to be increased or reduced are described* clearly and definitively so that all participants, both patient and staff, will have no doubt when the behavior has occurred. Descriptive terms are used; judgmental or diagnostic terms are avoided.

   c. **Replacement Behavior(s):** This section contains a description of the pro-social and desirable behaviors that are to be increased, improved or substituted for the targeted behaviors. These behaviors are described in behaviorally measurable terms so that different observers can all agree on whether the replacement behaviors have been exhibited.

   d. **Discontinuation Criteria:** This section specifies the criteria used to determine that the objectives of the Behavior plan have been met and that the plan should be discontinued or modified to a maintenance phase. The criteria must be written in behaviorally measurable terms.

   e. **Data to be Collected:** This section describes the data that will be collected to measure the patient's progress toward achieving the objectives of the plan. In addition, the staff person responsible for collecting and analyzing the data is specified in this section. Baseline and/or pretest data collected should also be included in this section.

f. **Intervention Procedures:** In a step-by-step fashion, the intervention procedures are described. This section must describe the steps of the behavioral intervention in enough detail that each individual involved is clear on exactly what to do and when. Specific staff must be identified as responsible for the various steps of the procedure. This section also includes the methods used to teach the specified replacement behaviors.

g. **Signature Section:** The patient's signature indicates that he/she understands the Behavior plan and agrees to participate. If the patient has a guardian, the guardian also signs and dates the plan. All staff involved in implementing the plan also sign the plan. Finally, relevant Treatment Team members sign to indicate their understanding and approval. The patient may discontinue the plan at any time.

7. All Behavior plans are submitted to the RPHBTC's Behavior Therapy Committee (RPHBTC) for review. Individual plans using only Recommended Proactive Positive Procedures may be implemented once the consumer and Team have signed the plan. Plans using Regulated Procedures must receive RPHBTC and HSBTC approval before being implemented. The RPHBTC and HSBTC may have additional requirements in terms of which plans require review prior to implementation.

8. Behavior plans making use of recommended procedures require review at least every three months. Behavior plans using regulated procedures must be reviewed at least every month. Written documentation pertaining to these reviews is forwarded to the HSBTC in a timely manner.

9. Active Behavior plans are filed in the Treatment Plan section of the patient's medical record.

Development of Group Behavior Therapy Plans

1. Treatment team identifies the need for a behavior therapy plan.

2. The behavior(s) to be addressed are determined and it is decided that a group behavior plan is the best approach.

3. A staff person with expertise in writing behavior plans takes primary responsibility to write the plan.

4. The most recent version of the HSBTC approved Group Behavior Plan form is used for writing the plan (a copy of this form can be found in the Behavior Therapy Manual – see Attachment 2).

5. The unit or group clearly defines each patient to whom the plan will apply. The plan is reviewed with all members of the unit or group. It is made clear that participation is voluntary and that, under no circumstances, will the group be penalized in any way for the performance, lack of performance, or lack of participation of any individual. The Behavior plan is referenced in each patient's Comprehensive Treatment Plan (CPT) And is an addendum to each patient's CPT.

6. The information placed in each section of the form is as follows:

   a. **Rationale for Plan:** This section states clearly what has already been tried, what the results of the previous interventions were, why a group plan was chosen, and the rationale for the current strategy.

   b. **Target Behavior(s):** The behavior(s) to be increased or reduced are described clearly and definitively so that all participants, both consumers and staff will have no doubt when the behavior has occurred.

   c. **Data to be Collected:** This section describes the data that will be collected to measure progress toward achieving the objectives of the plan. In addition, the person responsible for collecting and analyzing the data is specified in this section. Baseline and/or pretest data collected should also be included in this section.

   d. **Intervention Procedures:** In a step-by-step fashion, the intervention procedures are described. This section must describe the steps of the behavioral intervention in enough detail that each individual involved is clear on exactly what to do and when. Specific staff must be identified as responsible for the various steps of the procedure. Only recommended interventions may be used in Group Behavior Therapy Plans.

   e. **Signature Section:** The clinician responsible for explaining the plan to all involved individuals and ensuring that they have the right not to participate and to discontinue participation at any time signs indicating acceptance of this responsibility. Finally, relevant Treatment Team members sign to indicate their understanding and approval.

7. All Behavior plans are submitted to the RPHBTC for review prior to implementation.

8. Group behavior plans require review at least every three months. The RPHBTC may require reviews that are more frequent. Written documentation pertaining to these reviews is forwarded to the HSBTC in a timely manner.

9. Active Group Therapy Behavior plans are referenced in the CPT section of each patient's medical record and are an addendum to the patient's CPT.

Attachment 1

Individual Behavior Therapy Plan

Name: , .

PCS ID: Unit: Date:
Treatment/Recovery Plan Type of Plan:
Problem:

Plan Title:

Background Information/Previous Interventions/Rationale for Plan:

Target Behavior(s):

Replacement Behavior(s):

Discontinuation Criteria:

Data to be Collected:

Intervention Procedures (clearly describe what will be done and who will do it):

I have participated in the development of this plan. I understand it and I agree to participate in it. I understand that I can discontinue this plan. To do so, I can talk to any member of my Treatment Team or to the Client Rights Specialist.

_____

Patient Signature and Date

Guardian (if applicable) and Date	Psychologist
Psychiatrist	RN
Social Worker	Rehabilitation Services
Primary Care Provider	Other
Other	Other

DMH-TO16

Attachment 2

Group Behavior Therapy Plan

BHO Name Unit or Group: Date:

Plan Title:

Background Information/Previous Interventions/Rationale for Plan:

Target Behavior(s):

Data to be Collected:

Intervention Procedures (clearly describe what will be done and who will do it):

This plan will be explained to each individual whom it applies. It will be made clear that participation is voluntary and that there is no consequence to nonparticipation beyond losing any reinforcement that might be earned through the plan. It will be made clear that each individual may discontinue participation at any time. It will be made clear to each participant that if he or she, at any time, has any questions or concerns, he or she can talk to any member of the Treatment Team or to the Client Rights Specialist.

_____

Responsible Clinician/Date

RN	Psychologist
Psychiatrist	Social Worker
Primary Care Provider	Rehabilitation Services
Other	Other

DMH-TO17

Proactive Positive Intervention (PPI) to Promote a Culture of Safety and Healing on Inpatient Psychiatric Units

Behavioral Indicators	Behavioral Interventions
Environmental Situations	
Over Stimulation	
• excessive noise, light, color, activity • increasing activity, agitation, or anxiety among one or more patients • demonstrating increased pacing, yelling, throwing things	• offer to assist the individual(s) to a more quiet or calm place (comfort room) • prompt individual(s) to use relaxation/calming techniques • provide support through interacting or offer alone time • reduce stimulation (turn off radio/TV; engage others in calming interaction) • develop an individualized plan to assist in stimulus management through dialogue and collaboration
Under Stimulation	
• needing more action • provoking others to lose control or to fight • creating noise and disruption • occurring during low activity	• identify when behavioral occurrences occur • assign staff to engage in stimulating activities • help individuals to identify when s/he needs to do something or engage in different activities
Reputation - Macho or Superstar of Being Bad	
• using fear and intimidation to control patients and staff • talking about problems s/he has caused with indifference or pride • treating female patients or staff members as objects or sexual targets	• structure environment and unit program to reduce intimidating opportunities by increasing activities. • develop an individualized plan designed to create opportunity for success and provide attention to successes • staff avoid making comments on reputation or problems caused • develop clear, considerate and calm approach to individual

Behavioral Indicators	Behavioral Interventions
Patient Situations	
Anxiety/Tension	
Early indicators of escalating agitation like: • pacing • crying • disrupting unit • angry withdrawal • slamming doors • provoking/enlisting others to disrupt unit	**Interventions:** • Training staff to recognize early signs and symptoms and how to use intervention strategies. • Give bad news in a way which limits upsetting the patient. Team plan for this. • Relaxation therapy • Coping with anxiety and general coping skills groups • Counseling by trusted staff member or early intervention team member(s)
Escape from Task	
When doing certain tasks, the individual behaves in ways that: • result in being told to stop • being excused or removed from the situation **Problem behaviors may include**: • tantrums • provoking others • fighting; becoming loud/profane	**Environmental Change by Staff:** • Try to avoid power struggle over the patient completing the task. • Excuse them or offer help if when they start feeling uncomfortable • Encourage to return to the task when feeling more comfortable • Identify problematic components of task and change that component if possible **Individual Patient Training:** Train the patient in appropriate ways of coping with the task, or to be assertive about needs. • Patient to ask to take a break • Patient asks for a change in task • Train staff to respond positively to such patient requests and reinforce positive behavior • Encourage staff to vary patient tasks

Behavioral Indicators	Behavioral Interventions
Escape from Situation	
In certain situations the patient repeatedly behaves in ways that result in escaping the situation. Problem behaviors resulting in escape from situation: • Tantrums • Provoking others • Fighting • Loud and/or profane	**Environmental/Staff Response:** • Avoid power struggle with patient. Don't force to stay. • If remaining absolutely necessary, help patient understand why they must stay. **Individual Patient Training:** • Help patient understand what is unlikable about situation • Identify ways to improve the situation • Help patient develop different ways to respond to situation • Help patient plan to leave situation in appropriate manner • Reward (or praise) completion of each step in the above plan • Reward appropriate behaviors (even if only verbal praise)
Behaviors Occurring Following Admission	
Early indicators of escalating agitation. • Pacing • Crying • Yelling • Disruption • Angry Withdrawal • Slamming Doors • Provoking others into uproar/upset (sometimes occurs without the patient realizing it).	**Thorough and proper orientation of the patient to support and get them through the first few hours/days of a new admission.** • Visible staff • Written materials about hospital/ward • Ability to make private phone calls • Privacy • Choices • Communicate with him/her that we are here to help continue his/her recovery
Self Stimulation, Tension Reduction	
• Self-stimulation • Rocking • Pacing • Chronic masturbation • Head-banging	• Communicate to patient that we are here to help with recovery • Help patient use healthy behaviors to replace target behaviors • Encourage patient to recognize indications of increasing tension and employ relaxation techniques • Encourage patient to use techniques for appropriate self-stimulation (e.g. applying ice cubes, self-massage of hands or other areas, rubber band on the wrist). • Develop visualization of self-selected relaxation scenes; pair with relaxation to be able to induce relaxation with images. • Refer to psychologist (e.g. DBT, Behavior Plan).

Behavioral Indicators	Behavioral Interventions
Self Injurious Behaviors	
• Cutting • Swallowing Objects • Inserting Objects into wounds • Re-opening wounds • Chronic head-banging	• Primary TPW and RN should schedule time with the patient each shift to meet the patient's attention needs. (This is important - staff should develop trust and sense of safety for patient who feels unsafe and expresses a loss of control.) • If the person hides contraband (sharps etc.) on their person or in their room, then make regular searches of their room until trust is developed. • A "matter of fact" approach to SIB. The less emotion expressed the better. • Never contract to reduce self injury as it won't work and sets the patient up to feel more failure. Instead, help them to contract to do something positive. • Relaxation techniques should be used, both active and passive. When the patient is not in crisis, have them develop a list of strategies to use before resorting to self-injury. Specific staff prompts as developed in therapy & purposeful involvement with the TPW/PAT. • Quiet time not recommended. Staff attention (safety issues). • Nurse should de-brief the patient including what precipitated the incident and future strategies to manage/replace the SIB. • Look at the treatment plan and use specific interventions for patient processing developed with the input of the patient. • If increased supervision needed, utilize other interventions. • Dialectical Behavior Therapy or other evidence-based trauma therapy. • Psychiatrist/Clinical Psychologist/LISW should debrief and educate staff on all shifts about splitting techniques used by some patients with borderline personality disorder.
Patient Responding to Trigger of Previous Trauma	
• Frantic • Escalates greatly when in restraints. • Withdraws into a dissociative (almost catatonic) state when in restraints • Seems to be somewhere else • May experience flashbacks, re-experiencing the traumatic event • Difficulty in maintaining positive interactions	• The individual should be provided both pharmacotherapy and psychotherapy for this problem. If this is not completed during the admission, referral for continued post-discharge psychotherapy should be part of the discharge plan. • Important to note that Seclusion & Restraint is contraindicated for patients with a trauma history, except in rare situations. • Dialectical Behavior Therapy or other evidence-based trauma therapies depending on level of cognitive functioning. • In the milieu: identify and avoid "hot topic" issues related to triggers, flashbacks or trauma. • Debriefing with the client when a critical event happens on the unit (care must be given here as patient may not be in therapy).

Behavioral Indicators	Behavioral Interventions
Interpersonal Situations	
Patient to Staff Problems (Interpersonal Issues)	
Increased agitation. Patient • speaks with hostility • about or toward particular staff even when off-duty. • provokes staff, • becomes combative.	Re-assign staff or move patient if possible. Educate staff about patient's • diagnosis • need for tolerance/respect • need to maintain professional distance. Engage patient in interpersonal therapy to address issues. Teach or train on • Anger management skills, • relaxation skills, • conversational skills Reinforce patient when he/she approaches alternate staff by • offering full attention • attempt to meet patient's needs. Develop list of topics to avoid when interacting with problem staff.
Predatory Behaviors (Including Bullying and Stalking)	
Patient • verbalizes increased fantasies about potential victim. • becomes intrusive or aggressive toward vulnerable peer • sexual assault, including non-consensual touching • provokes a physical assault. • makes statements threatening others to remain quiet. • intimidates staff in an effort to get them to avoid him/her. Other patients fearful of predator-patient.	• Protect vulnerable peers by: • transferring them if possible. • Increasing supervision and monitoring of the person exhibiting the predatory behaviors. • Considering keeping on Level I for maximum observation. • Considering filing charges against perpetrator. • Clearly stating the limits of what behaviors will be tolerated and which will not. • Educating patient about the consequences of his/her behavior. • Encouraging and modeling good staff communication on the unit, especially with new or transferred staff. • When "grooming" behavior is observed distract by involving patient in therapy groups or activities.

Behavioral Indicators	Behavioral Interventions
Patient Targeting Patient	

Patient is:
 	
• making 'deals' with other patient.
• spending excessive time in room together, and,
  o avoiding others
  o huddling together,
  o conning,
  o otherwise manipulating each other.
  o showing increased agitation.
  o telling grandiose lies about other patient.
  o threatening,
  o increasing verbal harassment
  o challenging to fight.
 	
More vulnerable patient is increasing his/her complaints.
	• Consider transfer to separate units if possible.
	• Increase staff observation or monitoring.
	• Involve vulnerable patient in increased activities to avoid conflict situations.
	• Determine if patient is in competition with other
	• offer him/her a comparable B.T. program involving reinforcement for avoiding conflict with others.

Manic	
Patient: • Provokes other patients or staff members • Escalates or non-responsive to limit setting Staff: • Negative personal reaction to patient's provoking behaviors	Staff need to recognize/examine countertransference reaction behaviors Assign 1 staff to interact with patient during manic phase Use interactive style: • Set limits on topics • Avoid "hot button" subjects • Have conversations • Active listening—listen with respect Use previously identified interventions that are helpful (e.g. music or specified activities). Assist to resolve any reality-based "loose ends" in their life (e.g. call family member to feed dog or pay the rent to avoid loss of apartment. Transfer one of the patients for safety.

Behavioral Indicators	Behavioral Interventions
Paranoia	
Patient • Appears angry • Others bothered by that patient • Makes accusations about others (e.g. finger pointing) • Threatens harm to others	Watch for medication noncompliance • Cheeking • Spitting • Self induced vomiting Structure the environment • Provide maximal privacy when possible • Do not confront • General rules are enforced and emphasized • Forced medications if dangerous behavior or if other interventions fail. • Team needs to develop parameters for emergency medications • Link the medications to conditions the person acknowledges • Fear • Sleeplessness
Behaviors Brought from Their Experience	
Provocative or suspicious behaviors • Provoking others • Eliciting other peers to engage in antisocial behaviors • "Protecting" or otherwise intervening in others' business • Behaviors that require multi-staff intervention Threatening to harm others for personal gain	Observe for differences • Reported vs. Observed symptoms Encourage socialization in structured group activities to avoid isolating or singling out vulnerable peers Educate on: • Anger Management • Stress Management. • Identify cues or triggers that cause increased agitation and teach responses • Monitor stressful events such as scheduled court hearings. Possible candidate for trauma therapy

Behavioral Indicators	Behavioral Interventions
Substance Related Situations	
Needs – Tobacco, Caffeine	
• Constantly asking staff for cigarettes, coffee • Violating hospital rules about tobacco/caffeine use.	• Offer nicotine patches, nicotine gum, or smoking patch. • structured activities and interesting stimuli • smoking cessation groups to address the difficulties of quitting smoking. • Health education about smoking. • Follow "smoking grid"
Substance Withdrawal	
• Pt. becomes violent in search of alcohol and drugs; • Antagonizes others; • May exhibit increased psychosis; • Frequent pacing, asking for help, nervousness, fear.	• Quiet Room with relaxing activities • Physical exercise program to stimulate natural pain- killers. • SAMI referral • AA, NA, DRA groups • Refer to physician or psychiatrist for management of increased or newly detected physical withdrawal symptoms
Drug Seeking (Trying to Get High)	
• Behavior that reflects agitation (e.g., provoking or threatening others); • Taking drugs from other patients; selling or stealing	• Engage patient in SAMI programming or AA, NA, DRA. • Apply behavioral interventions • Relaxation training, offer replacement behaviors • Cognitive-Behavioral techniques (teach how beliefs may affect behavior).