Draft of Proposed Template to Guide the Development of

 Positive Behavioral Support (PBS) Plans

*The following headings in bold text highlight the important areas that are most often developed when constructing a comprehensive positive behavioral support plan. A detailed description within each subsection is offered.*

1. **Personal Background:**
* Information about the following areas from the records reviewed and the collateral sources may be included to better understand the biopsychosocial history of the person-served:
* Demographics
* Achievements and delays in developmental milestones
* Family relationships and dynamics
* Trauma, abuse, and neglect history
* Physical and medical conditions
* Neurological impairments (e.g., seizure disorder)
* Intellectual functioning (i.e., cognitive abilities related to knowledge, memory, reasoning, judgment, learning, and planning; severity of intellectual disability)
* Adaptive functioning (i.e., skills and deficits in meeting age-related and sociocultural standards for personal independence and social responsibility in the conceptual, practical, and social domains)
* Educational and vocational history
1. **Review of the Relevant History:**
* Include pertinent information from the diagnostic profile (e.g., DSM-V) and clinical formulations
* Describe any salient risk factors (e.g., suicidality, substance abuse, maladaptive personality traits, psychosexual issues, legal involvement)
* Discuss any recent changes in mental status, such as the signs and symptoms of psychiatric illness and the response to psychotropic medications
* Note current psychosocial stresses
* Identify the goals and readiness to change of the person-served
* Emphasize their personal strengths (i.e., interests, preferences, skills, protective factors, and supports)
1. **Referral Questions:**
* Identify the reasons that prompted the development of the positive behavioral support plan. For example, describe the ways in which the behaviors of concern (e.g., aggression, refusals) interfere with performance, participation, and/or progress.
1. **Rationale for the Interventions:**
* Describe the predisposing, precipitating, and perpetuating factors that may influence the person-served’s behavioral presentation. For example, low frustration tolerance and difficulties delaying gratification associated with severe intellectual disability often lead to impulsive behaviors.
* Obtain a history of the successes/failures of previous interventions (e.g., attempts at behavioral modification and management)
* What is the level of assistance that the person-served needs to learn and retain new information about their behavior (e.g., prompting, demonstrations, visual cues, verbal reminders, line of sight supervision)?

***Main Components of PBS Plans:***

In addition to the abovementioned areas, the following components are generally included in a thorough positive behavioral support plan. They are described and outlined below in greater detail.

1. Functional behavioral assessment (i.e., an information gathering process outlined below that *may* include a functional analysis).
2. Comprehensive interventions that include: (a) differentiating between behaviors of concern and targeted positive behaviors; and (b) proactive (preventative) strategies versus reactive (crisis) approaches.
3. Quality of life issues for the person-served.
4. Team approach (i.e., self-advocates, caregivers, and interdisciplinary stakeholders engaged in a collaborative process).
5. Data collection may be accomplished using a variety of formats.
6. **Functional Behavioral Assessment:**

*General Considerations:*

* Functional behavioral assessment (FBA) is a broad term that refers to information gathering and hypothesis development. It lays the foundation or “anchors” the positive behavioral support interventions. FBA can involve (1) direct observations, (2) indirect methods, and/or (3) functional analysis.
* In some instances, an abbreviated approach to the FBA can lead to reasonable interventions. In more complex cases, a systematic process is required. An appropriate FBA is one that is matched to the circumstances and leads to an effective behavioral support plan.
* The common goal of every FBA is to identify the function(s) or purpose of a challenging behavior. In this way, we can determine how to reduce the problem behaviors of the person-served by finding “functionally-equivalent” or “replacement” behaviors that help the person-served meet their needs more adaptively.
* FBA should also identify: (a) the changes that will be made to the environment (e.g., eliminating triggers, predicting the situations when the problem behaviors are most likely to occur) to prevent problem behaviors; and (b) determine how the new behavioral skills we be taught and reinforced.
* When conducting an FBA, it is important to prioritize the behaviors of concern to be addressed.

*Possible Approaches to FBA:*

1. Direct Observation: Also known as the Antecedent-Behavior-Consequence (A-B-C) approach. When a challenging behavior occurs, record the situational and contextual factors, such as what happened just before it, what occurred right after it, and what might be the hypothetical cause. Observations may be anecdotally documented by caregivers in note form or formal data collection tools can be used. The following elements should be addressed:
* *Topography*: A clear description of how each behavior of concern is performed that includes information about the frequency/rate, intensity, severity, and duration. The behaviors should be described in *measurable* and *observable* terms that everyone understands.
* *Setting Events and Vulnerabilities:* Situations in the environment combined with the deficits of the person-served where the behavior of concern is most and least likely to occur.
* *Antecedents:* The internal and/or external factors that occur *before* the behavior that might have triggered it. Consideration should be given to fast (immediate) versus slow (delayed) triggers. Categories of triggers include the following:
* *Physiological*(physical issues)
* *Psychological*(emotions, feelings or thought processes)
* *Social*(situations involving other people)
* *Environmental*(the surroundings)
* *Precursors:* Noticeable changes in the body language of the person-served that came *before* the behavior of concern (e.g., pacing, pressured speech, rolling their eyes, and clenching their fists).
* *Maintaining Consequences*: Events that occur *after* the behavior. How did the person-served caregiver’s respond immediately after the behavior of concern occurred? Is there inadvertent reinforcement of the challenging behaviors?
* *Function(s) of the Behavior:*
	+ Determinethe underlying reasons that give rise to the behaviors of concern or the outcomes that resulted from the behavior.
	+ The board categories of functions include communication, modulation of emotional distress, modulation of physical pain, and socioenvironmental control.
	+ Be mindful about the over-application of attention-seeking, manipulation, and/or escape as the possible functions of maladaptive behavior.
1. Indirect (Informant) Methods:
* Structured interviews and questionnaires that are completed by the person-served and their caregivers that identify a variety of factors. Participants may include family members, support professionals, friends, physicians, employers, and co-workers.
* Oftentimes, it is helpful to pose the following questions:
* Does the person-served understand the behavioral expectations for the situation?
* Does the person-served realize that he or she is engaging in unacceptable behavior?
* Is the problem behavior associated with certain environmental conditions? For example, who is present and what interactions take place prior to and immediately after the behavior?
* What has worked in the past to help stabilize behavior versus what has not?
* What was the person-served thinking and feeling before the behavior of concern?
* Is it within the person-served’s ability to control the behavior?
* Can the person-served identify acceptable behaviors to replace the maladaptive behavior?
* Does the person-served have the skills necessary to perform the new behavior?
* What modifications to the environment that have been tried to reduce problem behaviors and support more adaptive behaviors?
1. Functional analysis is the last *possible* component of a functional assessment.
* It is used only in specific occasions when we are uncertain about which functions are maintaining a behavior.
* Functional analysis is an experimental procedure in which hypotheses are tested by deliberately manipulating antecedents and consequences to see what impact they have on a behavior.
* It may be useful in some circumstances, but it is not always necessary or appropriate. Team collaboration, safety precautions, and ethical issues should be considered because a functional analysis may inadvertently encourage the person-served to engage in behaviors of concern.
1. **Identify the Behaviors of Concern** to decrease or eliminate in the following hierarchy:
2. Behaviors that threaten the health and safety of the person-served and others, such as physical aggression, self-injury, property destruction, and refusals with medical care.
3. Behaviors that pose a barrier to participation in services, such as verbal outbursts and refusals.
4. Inappropriate behaviors that hinder adaptive and social functioning, such as poor compliance with hygiene and isolative behaviors.
5. **Identify the Target Positive Behavior(s)** to increase through teaching, shaping, and reinforcement:
* Describe the adaptive and prosocial behaviors that will serve as replacements for behaviors of concern. For example, putting feelings into soft speech and polite words, rather than shouting to express frustration and disappointment. They should always have a direct “correspondence” to the behaviors of concern they are replacing.
* Always be mindful that the overarching goal of positive behavioral supports is the presence of targeted adaptive behaviors, especially an emphasis on the development of prosocial behaviors, rather than merely the absence of challenging behavior.
1. **Proactive Interventions:**
* These are the caregiver’s actions designed to help the person-served engage in their targeted behaviors and to avoid challenging behaviors.
* Proactive strategies deal with the conditions that precede the behavior and seek to reduce the future probability of the behavior. In addition, they help the person-served learn effective behaviors that will assist them in reaching their personal goals and lead to responsible choices.
* Proactive strategies include the following examples:
* Defining and teaching behavioral expectations for each activity
* Setting expectations in affirmative language (“do” rather than “don’t” form)
* Acknowledging and reinforcing the use of targeted positive behaviors
* Minimizing and eliminating triggers
* Prompting and cueing
* Establishing and adhering to a clear and consistent daily schedule
* Engaging in meaningful activities to improve the quality of life and a sense of well-being
* Critical scheduling (Premack Principle) of less preferred activities being followed by more activities to increase motivation
* Using a team approach
* Eliminating the use of coercion and punitive measures
1. **Reactive Interventions:**
* The caregivers’ actions to maintain calmness and safety.
* By definition, reactive strategies typically prescribe exactly when and how to intervene when a behavior of concern occurs.
* They should be used only an as necessary basis, as their goal is to either cut short the behavior of concern to minimize its effect or to extinguish it entirely.
* Reactive approaches include the following examples:
	+ Active Listening
	+ Empathic validation (acknowledgement, not necessarily agreement)
	+ Sensory modalities for soothing and relaxation (e.g., weighted blanket, soft music, warm beverage)
	+ Gentle redirection
	+ Limit setting
	+ Strategic giving-in
	+ One-to-one supervision in the household and/or community
1. **Lifestyle Enhancements**:
* These are based on the individual plan of the person-served, such as participation in pleasurable activities, opportunities for choice and control, meaningful relationships, and inclusion in community activities.
1. **Data Collection:**
* Graphing is a hallmark of positive behavioral supports. Graphs can be viewed as tools to clearly organize and record behavioral data.
* More specifically, graphs allow us to continuously evaluate treatment effects, as behavioral change is a dynamic process. For example, we can follow the person-served’s response to interventions and the caregiver’s fidelity with the positive behavioral support plan.
* Before implementing interventions, baseline data (e.g., interval spoilage sheets, ABC forms, Target behavior tracking sheets, progress notes, running logs, etc.) should be collected for a period of time (e.g., 2 to 4 weeks) to ensure a representative sampling. This allows us to compare the intervention data to the baseline data to determine whether the treatment is effective.
* Most often, the horizontal axis of a graph tracks the passage of time. The vertical axis usually displays dependent variables, such as the frequency of the behaviors of concern and the targeted prosocial behaviors.
* Line graphs are usually preferable to bar graphs because they easily show trends across time. Repeated measures (i.e., more data points) lead to greater confidence in estimating behavioral patterns.
* In addition to data points, significant changes in the course of treatment that may affect behavior can be reflected in the graphing. These interaction effects may include medication changes, emergent health issues, revisions in the behavioral strategies, and increased engagement in community services.
1. **Documentation and Training Requirements:**
* Family caregivers and agency providers may use a variety of methods to ensure fidelity to the behavioral support plan. These can include in-service trainings, periodic data reviews in team meetings, weekly clinical supervision, and ongoing consultations.
1. **Criteria for Success:** Theconsiderations in determining effectiveness of the behavioral support strategies for the person-served may include the following:
* Meaningful improvements in quality of life for the person-served, such as making better choices and demonstrating increased self-regulation over their emotions.
* Strengthened use of their desired adaptive behaviors and better engagement in alternative coping skills.
* Decreases in the frequency, intensity, and duration of challenging behavior.
* Reduction in the reliance on crisis interventions by caregivers.