Behavior Support Plan

I. DEFINITIONS

Behavior Support Plan (BSP)
The Behavior Support Plan is based on the findings from the Functional Assessment. The BSP contains directions for the staff/caregiver(s)/client to affect behavioral change and support the goals of the ISP and that of the client. As such, the BSP is written for those persons who are implementing the BSP and the language and concepts used within the BSP should be easily understood by the intended audience.

"Positive behavioral support procedures emphasize assessment prior to intervention, manipulation of antecedent conditions to reduce or prevent the likelihood that a problem behavior will occur, development of new social and communication skills that make problem behaviors irrelevant, and careful redesign of consequences to eliminate factors that maintain problem behaviors. Positive behavioral support is an approach that emphasizes teaching as a central behavior change tool, and focuses on replacing coercion with environmental redesign to achieve durable and meaningful change in the behavior of students. As such, attention is focused on adjusting adult behavior (e.g., routines, responses, instructional routines) and improving learning environments (e.g., curricular accommodations, social networks)."

---Online report by OSEP Center on Positive Behavioral Interventions and Supports: Effective school-wide interventions (technical assistance guide 1 Version 1.4.4, page 9) (12/01/99).

II. Outline for Behavior Support Plan

A. Identifying Information
B. Introduction
C. Behaviors to be Decreased
D. Replacement/Alternative Behaviors
E. Pro-Active Strategies
F. Re-Active Strategies
G. Documentation
H. Psychotropic Medications
I. Goals and Objectives
J. Statement of Risk
K. Statement of when and where the BSP is implemented
L. Signature page for IDT (including client, if possible) and HRC (if needed)
M. Record of staff training.

III. Identifying information

This information goes at the top of the BSP. The date the BSP was implemented (after staff have been trained on the BSP), the name of the person, date of birth (age), and the name of the author are essential. Other types of identifying information may be considered as needed:

- The person's address
- Residential Provider
- Case Manager

IV. Introduction

This section of the BSP should include a brief introduction describing the client (person-centered perspective), along with critical history relevant to behavioral problems that are interfering with the person's quality of life. A statement of the hypothesized function of challenging behaviors is presented here. This section should be no more than a paragraph or two in length and should be a basic introduction to the person and a concise summary of the functional assessment.

For example, this section may introduce the reader to "Mary", describing goals she has for her life, her interests, and her strengths (person-centered). Certain problem behaviors she uses (e.g., aggression, self-injurious behavior) are preventing her from reaching her life goals. Based on assessment, it is thought Mary is aggressive because she has no better way right now to get someone's attention or to ask for things that she wants. The goal of this behavior support plan is to ensure that Mary gets a lot of attention before she becomes aggressive and to teach her new ways to ask for things she wants to help her move beyond these challenging behaviors to a better quality of life.

Items to consider for the introduction are presented below. It is helpful to present information that is well-known and not likely to change for the individual, so that is remains relevant.

- Tell the reader who the person is and what is important to them
- State how certain behaviors are interfering with the quality of this person's life
- Describe why this person's behaviors are thought to occur
- Describe how this BSP will work to help the person have a better quality of life.

V. Behaviors to be Decreased

This section of the BSP simply names each of the problem behaviors and states the operational definition for that behavior.

For example:

<u>Physical Aggression</u>: Hitting, kicking, biting, slapping, throwing objects at others, or any other act that can potentially cause harm to another person if completed.

Definition: Operationally defined behavior is observable, measurable, and written so that others can agree when the behavior is occurring.

Within the body of the BSP, procedures for each behavior may be separated if needed. For example, behaviors that have the same function might also have the same procedures, but behaviors that do not have the same function may have different procedures. How this is done is up to the behavior consultant.

VI. Replacement/Alternative Behaviors

This section provides a means for new learning or some new intervention to occur that is intended add something to the person's behavioral repertoire that will assist them with meeting their goals. It is important to specify the details related to the use of positive reinforcement for these new behaviors, since new behaviors that are to be increased require some sort of positive reinforcement. As the new behavior is learned, then the particulars related to positive reinforcement may change.

Examples of interventions for this section may include the following:

- Teach a new behavior that is a functional replacement to the problem behavior. For example, if a person engages in aggression to escape task demands, they will learn a functional way to escape task demands that will make the aggression unnecessary.
- Teach communication skills or functional communication training
- Strengthen certain behaviors, or shape them, so they are more effective
- Teach relaxation skills
- Teach problem-solving skills
- Teach ways for the person to deal with his/her impulses
- Teach the person ways to deal with feelings or emotions
- De-sensitization techniques
- Point systems or token economies
- Thought stopping techniques or other cognitive techniques
- Teach the person new skills based on learning new information (e.g., adult relationships, cultural information, how to read body language, etc.).
- If the person is receiving scheduled training services from the behavior consultant or is receiving psychotherapy or counseling as part of this section, it is not sufficient to just mention that training or counseling as the only part of the replacement intervention for the BSP. As such, aspects of that part of treatment planning should be supported more frequently than those weekly, bi-weekly, or monthly sessions. For example, if the person is receiving counseling, asks the counselor what parts of his/her treatment plan for the individual could be supported more frequently outside of counseling sessions. Then, include some specific training in this section to support that treatment.

Skills that are being taught in this section should be those that the consultant is skilled in using or is supervised appropriately.

This part of the BSP requires data collection to see if the new training is having the desired outcome. If the training is not found to be effective, the training should be reviewed and/or revised.

VII. Pro-Active Strategies

This section of the BSP list procedures to address environmental setting events (slow triggers), antecedents (fast triggers) and antecedent behaviors identified in the functional assessment that are determined appropriate as part of the BSP. Clear, concise, and specific instructions to the caregiver regarding how to prevent problem behaviors are stated in this section of the BSP.

For example, it may have been found in the functional assessment, that crowded places, long van rides, and being told "no" have been associated with problem behavior in the past for Mary. It is also known that Mary begins to pace in her room prior to displays of aggression. Her aggression occurs for staff attention and she likes to help staff with house hold tasks. These items need to be addressed in the BSP:

1. Mary may not be in crowded places longer than 10 minutes at any given time.
2. Take 5 minute breaks outside the van after every 20 minutes during van rides.
3. Instead of telling Mary "No" when you can't assist her in meeting her needs right away, tell her (a)when you can assist her in meeting her needs or (b)when you will be available to talk to her about it.

4. When Mary is observed pacing in her bedroom, ask her to help you with some household task. After Mary is engaged in a household task for 10 minutes thank her and remind her that she can tell you if she would like to do some work, or spend some time, with staff.

VIII. Re-Active Strategies

This section of the BSP instructs caregivers on procedures following the display of problem behaviors. It is important to diminish or eliminate the reinforcing properties of the problem behavior. As such, instructions to caregivers are designed to lessen, minimize, or eliminate (as appropriate and safely possible) the maintaining consequences for the problem behavior(s). Following the display of problem behavior, instructions on how best to reintegrate that person back into the daily routine may be needed. Finally, crisis intervention plans or procedures may be needed in this section as well.

Any use of aversive consequences should not be used until lesser restrictive interventions (significant antecedent and proactive environmental manipulation, various types of replacement behaviors and various types of positive reinforcement) have been tried without success. Consequences that involve these restrictive elements must have prior approval from the IDT, guardian, and Human Rights Committee. Examples of aversive consequences are listed below:

- Exclusionary Time Out
- Involuntary Seclusion
- Manual Restraint
- Mechanical Restraint
- Chemical Restraint
- Response-Cost
- Corporal Punishment
- Aversive substances
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VIV. Documentation

This section of the BSP instructs caregivers how to complete data sheets related to the BSP. For each BSP, data collection on the problem behavior(s) and data collection on the replacement behavior(s) is required. If the person is taking psychotropic medications, a data collection system that addresses symptoms of the psychiatric condition being treated by the medication needs to be used as well. Other types of data collection may be useful as needed. The types of data collected may be adjusted at times to better inform outcomes.

Data collection procedures are designed to produce meaningful information that will help the behavior consultant identify weather interventions to support the person are successful (outcomes).

Types of data collection:

- Frequency data collection involves caregivers counting each instance of the behavior. Frequencies are tabulated and presented in the form of a graph. Frequency data collection is appropriate for those behaviors that occur at rates that are easily counted by staff.
- Interval data collection involves caregivers marking whether or not the behavior occurred during a specified interval of time. With this type of data collection, caregivers do not need to count each instance of the behavior, but only record whether or not it occurred during that interval (e.g., during a 15 minute period of time). Data is tabulated by the behavior consultant: divide the total number of intervals possible by the number of intervals that the behavior occurred, thereby producing a percent (%) of time the behavior is occurring. Interval data collection is appropriate for use with high-frequency behavior(s).
- Duration data collection involves caregivers recording the start time and the stop time for problem behavior. The behavior consultant tabulates the length of behavior and reports its increase or decrease in duration. Duration data collection is appropriate for behaviors when the goal is to decrease or increase the amount of time the person engages in the behavior.
- Intensity may also be measured, if operationally defined, and be useful related to some behaviors when this type of information is useful as part of outcome measures.

X. Psychotropic Medication

This section of the BSP only needs to be completed if the person is taking psychotropic medications. Since psychotropic medications are subject to change, this section of the BSP should be attached in a way that it can be revised as needed.

Include the following elements in this section of the BSP:

- List of psychotropic medications that are prescribed, along with the psychiatric diagnosis for which the medication is being used and the name of the physician who is prescribing the medications.
- List the side effects for each medication.
- List the types of data/information that will be shared by the IDT with the physician during medical appointments. For example, the IDT may bring data to the physician regarding the person's progress on ISP goals (how the person is learning), data on replacement behaviors for the BSP, sleep data, or other data as indicated in agreement with the physician.
- It is the decision of the physician, in concert with input from the IDT, on whether or how to stop, start, and/or reduce psychotropic medications.

<u>PRN PSYCHOTROPIC MEDICATIONS</u>
A PRN medication is a medication that is given only as needed to help the person under circumstances identified by the physician. Since PRN psychotropic medications are subject to change, this section of the BSP should be attached in a way that it can be revised as needed.

The following is a PRN medication protocol for psychotropic medications:

- Name of the person
- Date range of the prescription of the PRN
- Name of the prescribing physician and contact information
- Name of the PRN medication
- Side effects of the PRN medication
- Description of behaviors related to the use of the PRN medication
- Steps to be taken (procedure) prior to the administration and during the administration of the PRN.
- Documentation requirements, along with completion of an incident report
- IDT review following the administration of the PRN

Information regarding side-effects of medications needs to be done in consultation with the physician. One method is to get the information from a source (such as WebMD, or other source) and check that list with the physician for use. It is important that staff, caregivers, and individuals who take these medications are aware of the side-effects. This section of the BSP is still under review, including whether it should be in the BSP, and, if not, where it should be.

XI. Goals and Objectives

This section of the BSP states what outcomes are expected from the use of the BSP. Goals and objectives are written in comparison to the baseline data for both problem and replacement behaviors. A criterion triggering a review of the BSP is also included in this section.

For example, John's baseline for physical aggression is 4 times per month. The goal for the BSP is that John will have 2 or less episodes of physical aggression at the end of 90 days. John's replacement behavior is to sign for "break" to request a break. The goal is that John will use this sign 3 times per day at the end of 90 days. If John's aggression increases to more than 6 times in any given month or if he is using the sign for "break" less than 1 time per day, the BSP procedures will be reviewed.

XII. Risk/Benefit Statement

This section of the BSP lists the restrictive procedures of the BSP (e.g., any type of restraint, aversive consequences, and psychotropic medications) and weighs them against the expected benefits of the BSP. These are human rights restrictions and require the approval of a HRC committee. A statement of whether the IDT agreed that the risks outweighed the benefits is included.

XIII. Statement of When and Where the BSP is Implemented

This section describes the parameters of implementation for the BSP. If there are any exceptions to all the components of the BSP being followed by caregivers in daily settings, those should be stated here.