

**WHITING FORENSIC HOSPITAL**  
**OPERATIONAL PROCEDURE MANUAL**

<b>SECTION I:</b>	PATIENT FOCUSED FUNCTIONS
<b>CHAPTER 2:</b>	Provision of Care, Treatment and Services
<b>PROCEDURE 2.21</b>	<b>Guidelines for Positive Behavioral Support Planning and Implementation</b>
<b>Governing Body Approval:</b>	April 30, 2018
<b>REVISED:</b>	

**PURPOSE:** To develop for specific patients, explicit procedural strategies based on the principles of learning theory which reinforce contingencies (i.e., programmed consequences) to increase or decrease identified target behaviors.

**SCOPE:** For psychologists (who develop the PBSP) and staff (who implement them).

**POLICY:**

People who occasionally engage in difficult behaviors should be treated with compassion and respect. They are entitled to lives of quality as well as effective services. PBSPs have empirically been demonstrated to increase adaptive behaviors and reduce maladaptive behaviors in individual with severe psychiatric disabilities.

***Definitions:***

*Positive Behavioral Support Plan (or Planning) (PBSP):* entails instruction designed to teach skills and competencies to facilitate behavioral change. PBSP is rooted in Applied Behavioral Analysis. PBSP involves designing environments and interventions aimed at replacing problem behaviors with adaptive behaviors. PBSP is an approach to helping people improve their difficult behavior that is based on four premises:

1. People (even caregivers) do not control others, but seek to support others in their own behavior change process.
2. There is a reason behind most difficult behavior (a function).
3. A large and growing body of knowledge about how to better understand people and make humane changes in their lives can reduce the occurrence of difficult behavior.
4. Avoid coercion - the use of unpleasant events to manage behavior.

## **PROCEDURE:**

### **I. Indications for PBSP**

- A. A PBSP is indicated when 1) adaptive behaviors are not produced frequently enough for healthy adjustment or 2) maladaptive behaviors that harm the individual or others are produced too frequently for healthy adjustment.
- B. Examples of adaptive behaviors (target behaviors) include hygiene activities, good use of leisure time, polite interactions with peers, appropriate volume of speech, attendance at pre-vocational activities, etc.
- C. Examples of maladaptive behaviors (behaviors of concern) include behavioral excesses such as recurrent physical aggression against others, self-injurious behavior, and sexual compulsion, as well as behavioral deficits such as self-care deficit, apathy, avoidance, and treatment refusal.
- D. The purpose of a PBSP is to increase the occurrence of target behaviors. A fundamental assumption of PBSP is that behaviors of concern will decrease in frequency as target behaviors are emitted consistently. PBSP do not entail the application of aversive consequences of any sort (no response cost), because emphasizing behaviors of concern tends to inadvertently and intermittently reinforce these behaviors.

### **II. Components of PBSP**

#### **A. Function of behavior**

Behaviors are maintained by consequence events (function) through positive or negative reinforcement. PBSP requires identifying the function of a behavior, i.e., what need it meets. Behaviors are occasioned by antecedent events. Changing behaviors requires consideration of maintaining consequences.

#### **B. Functional behavioral analysis (FBA)**

A FBA is a systematic process to identify factors that contribute to occurrence and maintenance of problem behaviors. It serves as basis for developing proactive and comprehensive PBSP.

1. It consists of:
  - a. clear and measurable definition of behavior of concern;
  - b. complete testable hypothesis regarding the function of the behavior of concern;
  - c. integration of psychological and neuropsychological assessment findings;
  - d. data to test hypothesis; and
  - e. a PBSP based on hypothesis.

### III. Definition of behavior of concern

- A. A FBA requires an objective and measurable definition of individual behaviors of concern. These may be embedded in response chains, i.e., predictable sequences of behaviors, and fall in response classes, i.e., topographically different behaviors with similar function (e.g., obtain attention, escape task request).
- B. The basic working unit of a FBA is a testable hypothesis, a “best guess” about behavior and conditions under which problem behavior is observed. It entails linking setting events (i.e., situation in which the problem behavior is more likely to occur), trigger antecedents, problem behavior, and maintaining consequences (i.e., the stimuli that follow the problem behavior and maintain or increase its likelihood).
- C. Data is then collected to test the FBA-derived hypothesis. When data do not support hypotheses, then all information is reviewed and more is collected, so that the hypothesis can be changed and the new hypothesis is tested.

### IV. Teaching alternative behavior

Alternative/desired behaviors need to be identified, taught, and rewarded. This creates competing pathways to the behavior of concern. To promote his/her recovery, the individual and, if appropriate, his/her family need to be involved in this process in order to express their wishes and preferences.

### IV. Eliminating behaviors of concern

Strategies to eliminate behaviors of concern include: modifying antecedents so that they no longer trigger the problem behavior; designing teaching strategies to make problem behavior inefficient (and acceptable behavior easier); designing consequence strategies to make maintaining consequences ineffective (i.e., less often present or less reinforcing); design setting event strategies to neutralize effect of setting events.

## V. PBSP requirements

- A. PBSPs are devised only in the context of an inter-disciplinary treatment approach and based on multidisciplinary assessments. As with any other treatment strategy, they must have the approval of the team psychiatrist and may require in some cases a written order to ensure consistent application.
- B. A team considering the use of a PBSP contacts its psychologist. The team psychologist, if not credentialed in PBSP must, after preliminary consultation with the inter-disciplinary team, establish a peer consultation relationship with another psychologist who is so credentialed through the director of psychology.
- C. All PBSPs include an evaluation procedure to review, modify, and, if appropriate, terminate the plan. All plans are reviewed by the director of psychology, who may seek consultation from the Behavioral Intervention Service at CVH (covered under the MOU for Behavioral Intervention Consultation).

## VI. Credentialing

PBSPs require that the psychologist who is designing the treatment be appropriately credentialed and currently competent, or if necessary, supervised by another psychologist with relevant credentialed expertise. If a PBSP is used, this must be conducted in a manner consistent with the guidelines outlined in this section.

## VII .Joint Commission requirements

- A. The use of PBSP is approved by the Medical Staff and the Governing Body, and is supervised by staff trained in the specific area of PBSP. All staff involved in carrying out PBSPs has been trained in program implementation. All PBSPs are implemented in a clear, consistent manner, and contain a continuous measurement and assessment component with adequate summary of the data into a useful form of presentation (graphs, narratives, etc.), and have methods of feedback from the client, staff or significant others in order to alter the program to meet the individual's changing needs.
- B. Strategies traditionally known as "aversion therapy", which involve the application of a noxious stimulus to eliminate maladaptive behaviors, are not employed at Whiting Forensic Hospital.