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DEPARTMENT OF HEALTH
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DEVELOPMENTAL DISABILITIES DIVISION

TITLE: Positive Behavior Supports Policy #: 2.01

PURPOSE:

Historically interventions used for people with intellectual and developmental disabilities (I/DD) have been unacceptably intrusive, focused primarily on punitive consequences, inappropriate for integrated settings, and/or ineffective in producing meaningful changes. Positive Behavior Supports (PBS) are preferable because they are effective in improving behavior and quality of life for people with behavioral challenges. The Developmental Disabilities Division (DDD) is committed to using approaches that will increase the safety, independence and overall well-being of participants receiving services. While the goal of this policy is to safely support participants who may engage in challenging behaviors, it also strives to promote participants' engagement in integrated activities.

The fundamental features of this policy include a foundation built on person-centered values, a commitment to outcomes that are meaningful, and services individualized to each participants' unique interests and strengths. The primary purposes of this policy are to commit to approaches that embrace the unique strengths and challenges of each participant, and engage each participant's circle of support as partners in developing and implementing PBS using least restrictive interventions. When a participant presents behaviors that put them at imminent risk of hurting themselves or others, PBS shall be used, whenever possible, to decrease the behaviors that pose a risk. When PBS techniques have been used and are not effective in resolving the immediate risk of harm, restrictive interventions that involve temporary restrictions may be necessary *(refer to Policy 2.02, Restrictive Interventions)*. Behavioral support plans (BSP) containing restrictive interventions are the least desirable approach to supporting participants and should only be utilized for the protection of the participant and others. Ultimately, this policy sets forth the core values of supporting participants to the best of their abilities by expanding opportunities and enhancing quality of life using PBS approaches.

DEFINITIONS:

"Behavior Support Plan" or "BSP" is a written plan for the team members who are supporting the person who is engaging in behaviors perceived as challenging. The BSP outlines:

1. Steps that will be taken by the members of the person's team to modify the physical environment;

2. What replacement skills should be taught to the participant as well as how to do so;
3. Ways in which team members should respond to challenging behaviors; and
4. Ways in which team members can decrease the likelihood of challenging behaviors.

The BSP is developed based on the results of a Functional Behavior Assessment (see definition below). As BSPs include Positive Behavior Support approaches (see definition below), a BSP may also be referred to as Positive Behavior Support Plan or PBS Plan.

"Functional Behavior Assessment" or "FBA" means the process of determining the functions, or reasons why a person is engaging in challenging behaviors, and to understand the conditions in which challenging behaviors occur. The FBA involves collecting data to identify patterns or trends and to develop a hypothesis of conditions that trigger and/or maintain these behaviors prior to developing a behavior support plan.

"Person-Centered Planning" means an ongoing process directed by the participant that helps individuals in his or her circle learn how the participant wants to live and describes what supports are needed to help the participant move toward a life considered meaningful and productive.

"Positive Behavior Supports" or "PBS" is a process for addressing challenging behaviors by understanding the relationships between a person's behavior, communication, and aspects of his or her environment. It offers strategies to modify the environment and interactions in order to prevent the occurrence of these behaviors; teaches skills to replace challenging behaviors; outlines responses to challenging behaviors to reduce the likelihood that these behaviors will reoccur in the future; and offers proactive and functional strategies to promote a positive lifestyle change. Positive Behavior Supports strategies are included in Behavior Support Plans (BSPs).

"Trauma Informed Care" or "TIC" is a developmentally appropriate, strengths-based approach that creates opportunities for people who have experienced trauma to rebuild a sense of control and empowerment. TIC is grounded in an understanding of and responsiveness to the impact of trauma and emphasizes physical, psychological, and emotional safety for both providers and survivors. It involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to maintain and/or exacerbate the impact(s) of trauma and/or re-traumatize individuals who have histories of trauma. It upholds the importance of consumer participation and choice in the development, delivery, and evaluation of services. When appropriate for a participant, TIC recognizes trauma recovery as a primary goal of treatment which involves systems integration and a basic understanding of trauma, triggers, and the impact trauma may have had on a participant's development and coping.

CORE PRINCIPLES:

PBS methods should be the primary interventions used to maintain the safety of participants and others, promote the independence of participants, and safely support participants who engage in challenging behavior(s). The following principles serve as the foundation for guiding and implementing PBS interventions with participants:

A. **Respect:** All participants must be treated with respect and dignity. All interventions must be free from practices or interactions that are degrading, humiliating, painful, or harmful.
B. **Least Restricted Intervention:** Ensure that the most proactive, effective, and least intrusive methods are utilized.
C. **Person-Centered Services:** Specific needs of each participant are identified based on an individualized assessment that incorporates the preferences, values, lifestyles, strengths and abilities, and social circumstances of the participant.
D. **Most Integrated Setting:** A setting that enables participants with disabilities to interact with non-disabled persons to the fullest extent possible.
E. **Meaningful Activities:** Participation in meaningful and purposeful activities that are interesting and motivating as determined by the participant.
F. **Independence:** Participants learn functional skills, which are used in their daily routine and necessary to participate in the community in order to enhance their quality of life.
G. **Individualization:** Behavioral interventions are designed to meet the unique and individual needs of the participant.
H. **Choice:** Encourage individual choice in daily decision-making.
I. **Access to Services:** Participants should have timely access to quality services.
J. **Family Support:** It is essential for the circle of support members, particularly family and caregivers, to participate as partners in the design of behavioral interventions. Families and/or caregivers may often need continuous support when developing and/or implementing behavioral interventions.
K. **Cultural Competency:** Support of a participant should incorporate the priorities and needs of the individual as well as his/her cultural and ethnic backgrounds and values.
L. **Collaboration:** Effective change is achieved through the circle of support working together to understand the goals and recommended strategies. Collaboration ensures that members of the circle have adequate resources and support to consistently implement the recommendations.
M. **Consistency:** Ensure consistency and continuity between and within services. The behavioral supports must be compatible and sustainable with existing routines in the participant's natural environment.
N. **Communication:** Involve all members of the participant's circle of support, including but not limited to family members, caregivers, friends, service supervisors and direct support staff. Ensure clear communication of the interventions to those directly involved.
O. **Skill Development:** An absolute belief that every participant has the potential to learn new adaptive skills, with all members of the participant's circle of support working to determine how to teach such skills to meet the unique strengths and capabilities of the participant.
P. **Trauma Informed Care:** An organizational structure and framework that involves comprehensive understanding, recognizing, and responding to the effects of all forms of trauma, when warranted by the individualized needs of the participant.

POLICY:

DDD establishes that PBS practices and procedures - which serve to support a participant's engagement in positive behaviors and helps them to lead meaningful and productive lives - shall

be the primary interventions used when supporting participants. This Policy applies to services authorized by the participant's Case Manager (CM).

A. A BSP will be developed to support participants who engage in behaviors that threaten the health and safety of themselves or others, or that limits or prohibits the participant from engaging in an integrated activity. PBS approaches shall be the primary interventions proposed for use in a BSP to safely address challenging behaviors and increase a participant's independence and integration into community activities.
B. A BSP will take into account an understanding of the participant's behavior by collecting and using data to make decisions. When appropriate, a trauma-informed care approach will be incorporated into a BSP to meet the individual needs of a participant with a history of trauma and/or abuse.
C. A BSP will be developed and implemented for all participants receiving more than a 1:1 staff ratio with services in place to address health and safety goals, with regards to reducing challenging behaviors. The BSP must include recommendations and criteria on when to transition to a 1:1 staff ratio.
D. The BSP must be overseen by a qualified DDD provider.

PROCEDURES:

A. A BSP must be developed by a licensed professional in accordance with Hawaii state law.
B. The Clinical Interdisciplinary Team (CIT) or designee may assist with assessing any medical, trauma, and/or mental health concerns that may impact the onset or exacerbation of challenging behaviors.
C. The BSP is developed using the following set of criteria;
    1. Building a PBS team: The PBS team members are anyone who provides services or support to the participant. These members must coordinate their work at all times when developing, implementing, and/or monitoring the participant's BSP.
    2. Person-Centered: It is important to identify goals that are not only limited to addressing challenging behaviors, but goals that also enhance the participant's overall quality of life. The following questions shall be considered when developing goals:
        a. How can participation and inclusion in the participant's home and community be increased?
        b. How can we increase the meaningful activities that a participant engages in?
        c. What would increase or strengthen the participant's social support?
        d. How can we increase a participant's ability to make appropriate choices and control aspects of their life?
        e. What barriers may interfere with the participant's progress?
    3. Defining the Target Behaviors: In order to monitor the outcomes of an intervention, specific behaviors of interest, also known as target behaviors, need to be defined in a concrete and observable manner. This definition should be written in clear, concise, and measurable objective terms (what the participant does or says). Target behaviors may be defined by answering the following questions:
        a. What does the behavior look or sound like?

b. How often does the behavior occur (e.g., frequency, duration measure)?
c. How intense is the behavior (e.g., does the behavior result in bruising or breaking of skin)?
d. Is the behavior harmful to the participant or others?
e. Does the behavior result in property damage?
f. Does the behavior prohibit or limit the participant's engagement in integrated activities?
g. Is the progress of the participant or others being affected?

4. Functional Behavioral Assessment: The FBA must include the following components:
   a. Review of relevant records, such as but not limited to, Adverse Event Reports, Individualized Service Plans (ISP), and/or provider quarterly reports.
   b. Interviews with multiple people who interact with the participant regularly in different settings and activities.
   c. Direct observations of the participant across multiple settings, activities and interactions with various people.
   d. Individualized assessments to determine broader variables affecting the participant's behavior.
   e. Collection and analysis of objective information regarding the following:
      1) Baseline data of the challenging behavior as well as signals that indicate more serious behavior is about to occur (e.g., threatening gestures, pacing, muttering).
      2) Antecedents (conditions that precede the occurrence of the participant's behavior) such as the time, setting, activity, and the people who are present or absent when challenging behaviors occur.
      3) Consequences (conditions that immediately follow the occurrence of the participant's behavior), such as if staff respond to the behavior by giving attention or removing undesirable activities.
      4) Setting events (ecological or motivational conditions) such as lack of sleep, skills deficits, change in routines, illness, or difficulties with crowded places.
   f. One or more statements that summarize the patterns of behaviors, including the triggers and consequences, and offers an educated hypothesis for the function of the challenging behaviors and what may be maintaining it based on the objective data collected.
5. BSP Development: The FBA provides the basis for developing the BSP. The date(s) each of the FBA component activities (detailed in item 4 above) occurred must be documented in the BSP. This should include relevant details regarding the FBA activity completed (e.g., where an observation took place, the date, and who was present; who was interviewed, the date, and findings; what assessment was administered, the date, and results) as well as a list of the records that were reviewed by the author of the BSP, including the date indicated on the record and relevant information/findings.

The BSP facilitates the attainment of broad goals identified by the team and promotes the sustainability of the behavioral change. The BSP must include:

a. Modifications to the social or physical environment that may prevent the challenging behavior and/or increase the likelihood of alternative appropriate behaviors.
b. Identification of specific behaviors or skills to teach and/or reinforce that will achieve the same function as the challenging behavior and that will allow the person to more effectively manage or respond to the environment.
c. Strategies for managing consequences so that positive reinforcement is provided for proactive behaviors.
d. Interventions that should be utilized during earlier stages of behavior escalation to prevent imminent risk of harm to the participant or others.
e. Detailed information on how data will be collected and analyzed by individuals implementing the BSP to evaluate the effectiveness of the plan for *each* objectively defined target behavior and goal.
f. An outline of crisis management procedures and the conditions in which they should be applied, should it be necessary to implement in order to ensure safety and rapid de-escalation of challenging behaviors.
g. Detailed information on how the author of the BSP will train all members in the participant's circle of support as well as documentation of how these individuals respond to the training (e.g., are they able to independently apply interventions appropriately). The service supervisor and caregiver(s) must be involved in the training of the BSP.
h. PBS strategies shall be the primary interventions used when supporting participants. If a restrictive intervention is proposed for use in a BSP, these interventions shall only be used on an emergency basis to prevent imminent risk of harm to the participant and/or others and applied only after less restrictive interventions were used and deemed ineffective, with appropriate documentation demonstrating their ineffectiveness. DDD's requirements regarding the documentation, data, training and supervision, interventions, and plans that must be included in BSPs involving restrictive interventions are detailed in *Policy 2.03, Behavior Support Review*.

6. Implementation and Monitoring: Specific procedures for implementing each intervention must be outlined in the BSP and progress toward the goals must be monitored as defined below:
   a. The PBS team must discuss and document the training(s), support(s), and/or other resources that may be needed to implement the BSP (e.g., supplementary aids or equipment).
   b. The BSP must include specific objectives and activities, identify responsible persons, and set reasonable timelines.
   c. Training on the BSP must be provided to all members of the PBS team and shall include, but not be limited to, a review of written materials, PBS approaches, and other interventions individualized for the participant, face-to-face behavioral

modeling and coaching, feedback on the application of an intervention, instructions on data collection and review methods, and assistance in restructuring routines, curriculum, instructional strategies, schedules and/or activities to minimize the likelihood of a challenging behavior.

d. Plan implementation must be monitored through observation and data analysis to ensure intervention strategies are implemented appropriately and consistently across settings.
e. Objective data must be collected to evaluate the effectiveness of the BSP. Data should include decreases in challenging behavior, increases in replacement skills, achievement of broader goals, and staff implementation.
f. The PBS team must communicate regularly on a schedule defined by the team, to review progress and adjust the BSP as necessary.
g. The goals of the BSP shall be incorporated into the participant's Individualized Service Plan (ISP) by the participant's CM.

D. An initial authorization of Training & Consultation (T&C) for Behavior Analysis may be authorized by the CMB Section Supervisor for a limited number of hours (up to five hours). The purpose of the initial T&C authorization is to enable a qualified provider to make a determination based on data of the need for a formal request to the CIT for additional hours of T&C to complete the FBA and BSP.
E. The CIT shall make the decision whether or not to authorize T&C hours for a licensed professional in accordance with Hawaii state law to complete a FBA and BSP.
F. The CMB Section Supervisor may authorize the author of the BSP to provide ongoing monitoring of the implementation of the BSP, retraining on the BSP, if necessary, and the collection and review of relevant data. This ongoing monitoring shall not exceed four (4) hours per month at a maximum of 6 months following completion of the initial training on the BSP. These hours shall not be used by the author of the BSP to complete tasks or other duties that are the responsibility of the DDD provider's service supervisor. A request for additional hours per month and/or an extension of the ongoing monthly supervision by the author of the BSP must be requested through the CIT. The CIT may authorize additional hours following a review of data and/or documentation which demonstrates the need for increased hours and provides detailed information regarding how previously authorized T&C hours were utilized. The author of the BSP or his/her designee shall also provide the CIT with a detailed description of how the additional hours will be used each month to improve the implementation of the BSP and/or collection of data.
G. The CM must initiate contact with a T&C provider within five (5) working days of receiving written authorization from the CIT. The CM must report back to the Case Management Branch (CMB) Section Supervisor if a T&C provider has not been retained within 14 calendar days from the date the T&C approval was received. The Unit Supervisor may call the Section Supervisor of the Community Resource Management Section (CRMS) within the Community Resources Branch (CRB) for assistance in locating a provider.

H. Once the FBA is completed, a BSP must be developed and written within 14 calendar days and shall include the date (month, day, and year) the BSP report was completed as well as the name of the author and his/her credentials. A final copy of the BSP report shall be forwarded by the author to the CM within 2 business days of the date of completion indicated on the BSP report. Refer to *Policy 2.02, Restrictive Interventions*, for additional BSP requirements.

I. Training must be initiated by the author of the BSP within 7 calendar days of the completion date indicated on the BSP and shall include a face-to-face training of, at minimum, all of the interventions and data collection methods included in the BSP by the author for all individuals in the participant's circle of support.

J. Documentation of challenging behavior(s), including the effectiveness of the recommendations and/or interventions indicated in the BSP, shall be reported by the DDD provider to the CM every quarter or more frequently, as documented in the ISP.

K. If a restrictive intervention is included in a BSP to address a challenging behavior, such interventions are permitted only when PBS strategies and less restrictive interventions have been applied first and deemed ineffective. Refer to *Policy 2.03, Behavior Support Review*, for the DDD's requirement specifications for BSPs that include restrictive interventions as well as when review by the Behavior Support Review Committee is required.

L. The BSP must be reviewed at least annually by the participant's circle of support and updated as needed.

M. A copy of the participant's current BSP must be accessible at the participant's home, and to all staff who work with the participant at the setting in which the DDD service is provided.

N. Staff who work with the participant must implement the procedures as written in the BSP. If modifications are needed, staff must refer to a qualified professional.

O. At minimum, the author of the BSP must remain on the participant's team until training and implementation of the plan is completed. The author should also be available to provide periodic monitoring of the BSP (not to exceed four hours per month) to ensure that it is being consistently and correctly implemented by all individuals in the participant's circle of support. If the author of the BSP is unable to provide ongoing monitoring of the BSP, he or she must appoint an appropriate designee who complies with Hawaii state law before transitioning off the team. It is at the discretion of the PBS team, with support from the CIT, to request another licensed professional in accordance with Hawaii state law to assume responsibility of the BSP.

P. The DDD provider's service supervisor needs to demonstrate a level of competency on the BSP following training from the licensed professional in accordance with Hawaii state law who developed the plan.

Q. All staff who implement the BSP must comply with Hawaii state law. A licensed professional in accordance with Hawaii state law shall train on the implementation of the BSP and provide periodic monitoring of BSP implementation.

R. T&C services will not duplicate services provided through another source, including Applied Behavior Analysis (ABA) services covered by a participant's commercial

insurance or, if the participant is under 21 years of age, through the Early Periodic Screening Diagnostic and Treatment (EPSDT) services under the Medicaid QUEST Integration Health Plan. When a participant has a BSP developed through another source (e.g., Department of Education, QUEST Integration, and private insurance), T&C may be authorized to develop a BSP to address behaviors that occur in settings where DDD services are provided. The author of the BSP shall ensure consistency amongst and across the services the participant receives by consulting with the authors of the other BSPs and their treatment teams and utilizing similar interventions in settings where DDD services are provided, where appropriate. This T&C shall include training in implementing the BSP strategies and approaches during waiver service hours, as well as providing periodic monitoring of the BSP to ensure consistency.

AUTHORITATIVE & OTHER REFERENCES:

1. Koegel, L.K., Koegel, R.L., & Dunlap, G (1996). *Positive behavior support: Including people with difficult behavior in the community.* Baltimore: Paul H. Brookes Publishers.
2. O'Neill, R.E., Horner, R.H., Albin, R. W., Sprague, J.R., Storey, K., & Newton, J.S. (1997). *Functional assessment and program development for problem behavior: A practical handbook.* Pacific Grove, CA: Brooks/Cole.
3. Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014
4. Chapter 465D, HRS, "Behavior Analysts"[1] http://www.capitol.hawaii.gov/hrscurrent/Vol10_Ch0436-0474/HRS0465D/HRS_0465D-.htm
5. DD Policy 2.02, Restrictive Interventions
6. DD Policy 2.03, Behavior Support Review

Approved: Mary Brogan **Date: Feb 17, 2017**

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[1]This hyperlink connects to the most recent version of HRS through the Hawaii State Legislature website. Hyperlinks to HRS chapters show the first page of the chapter only, to see the rest of the contents of the chapter, click "Next" on the lower right hand side of the page on your screen.