Practice Guidelines for Behavior Support Plans

The following resource provides basic guidelines on the minimum elements that constitute an adequately designed behavior support plan for individuals receiving therapeutic consultation behavioral services under the Family and Independence Supports (FIS) and Community Living (CL) Developmental Disability Medicaid waivers in Virginia (note: the term 'behavior support plan,' or abbreviation 'BSP,' is synonymous with "behavior treatment plan" in sections 12VAC35-115-105 and 12VAC35-115-110 of the Department of Behavioral Health and Developmental Services ("DBHDS") Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services ("Human Rights Regulations"). Additionally, there is supplemental information included subsequent to these guidelines on the use of the least restrictive and most effective treatment philosophy and positive behavior supports, utilizing person-centered thinking and planning, and incorporating a trauma informed approach as it relates to behavior support planning. Further, following the literature review, there is an associated visual that provides a summary of the authorization types, associated timelines for each authorization, and required documentation. Behaviorists should reference the permanent DD waiver regulations for this service to review the entirety of regulatory requirements, available here: 12 VAC 30-122-550.

Practitioners that are billing therapeutic consultation behavioral services have already demonstrated a particular level of competency by obtaining appropriate licensure, credentialing, or endorsement in the field. As with any human service provider that obtained a credential or license through a certification, licensing, or endorsing board, there are rigorous ongoing requirements that must be adhered to in order to maintain their professional status. It must be noted, it is not the intention of the information below to supplant codes of ethics or standards of practice for a behaviorist; practitioners must always practice within the limits of their professional training and in adherence with their governing code of ethics and standards of or scope of practice. Instead, what is indicated in the table which follows are: 1) minimum required BSP content areas; and 2) minimum elements, notes/additional information for each of the required BSP content areas. DBHDS suggests that authors of behavior support plans be mindful of the audience of and those implementing behavior support plans as it relates to the use of extensive technical jargon.

Minimum BSP Content Areas and Elements

Minimum required BSP Content area	Minimum elements and notes/additional information
Demographic information	*Minimum elements:* *Individual's name, DOB, gender identification, medical /behavioral health diagnostic information, medications if known, current living situation, Medicaid ID, legal status, date of initial plan and revisions (and nature of revisions), authoring clinician's name/credentials/contact information, and the individual's location related to where the BSP is going to be implemented.* *Note: Include as much pertinent information as possible in this area; it is understood that the behaviorist may not have comprehensive records of all medications or the entirety of diagnostic information. Include known influences of medical/behavioral healthcare conditions and treatment on behavior presentation.*
History and rationale	*Minimum elements:* *Current and/or relevant historical information about this person and their life, the reason and rationale that the behavior support plan is being implemented/necessity for formalized intervention as it relates to challenging behaviors, and any known history of previous services and the impact of these services on both challenging and desired behaviors. If there is clear information on a history of trauma, it must be included in this area (note: when indicated, trauma informed considerations must be included in other appropriate content areas of the BSP; see related section in these Practice Guidelines on "Trauma informed care in behavior support planning"). Describe any dangerous behavior to include topographies, intensities, and associated risks and/or negative outcomes. Include risk and benefit information related to prescribed behavioral programming; this includes potential risks of physical and psychological harm or other potential negative outcomes as well as the benefits of prescribed interventions.*
Person centered information	*Minimum elements:* *This area must include the individual's communication modality, preference assessment information/results, cultural/heritage considerations (if known), routines/current schedule, individual's strengths and positive contributions, and particular aversions/dislikes. Information must be incorporated from the larger ISP as needed as it relates to behavior planning and updated with the annual shared planning meeting, which includes individual and guardian's participation. As part of the identification of preferences, identify who in the individual's life is especially preferred and what activities are enjoyed and sought by the individual.* *Note: There are numerous person-centered planning tools, indirect reinforcer surveys, and empirical preference assessment procedures that can be accessed through publicly available resources in behavior analysis, person*

	centered planning, and positive behavior supports. Several resources are located in the section labeled "Person Centered Practices in Behavior Support Plans" later in this document.
Functional Behavior Assessment	*Minimum elements:* *Include information as to 1) when/where the FBA was conducted, 2) the FBA methods used (e.g. interviews with caregivers, ABC recording techniques, behavior checklists/rating scales, functional analysis, etc.) and 3) the associated results and analyses (e.g. setting events/motivation operations, antecedents, and consequences associated with the target behavior). Include data results and/or graphical displays of findings from the FBA as appropriate. If there are any known non-operant conditions that influence behavior, include such information in this section. In conjunction with the preparation for the shared planning meeting, the behaviorist must review the FBA and treatment data and make a determination if the functions are still valid or if the FBA must be revised and updated. A reassessment of the functions of behavior is required when data suggest treatment expectations are not being met or there has been a significant change in status of the individual that is negatively effecting the treatment outcomes. The review of the continued validity of the FBA, or the reassessment results from the FBA, must be documented in the FBA section of the BSP annually.* *Note: Basing the behavior support plan solely on the results of indirect FBA methods (e.g. interviews, rating scales) is not adequate. Such methods may be useful in formulating hypothesis to inform the FBA process, but overall indirect FBA methods have significant reliability and validity limitations. At a minimum, descriptive assessment that analyzes the relationship between antecedents and consequences surrounding challenging behavior must be conducted. The FBA should be conducted in the setting in which behavioral treatment is to occur. There is also a BSP content area on hypothesized functions of behavior, which can be incorporated into the FBA area. Include information on setting events if this is apparent based on the FBA process. Functional analysis (e.g. experimental functional analysis procedures) has the highest degree of validity amongst all FBA methodologies and is the "gold standard" in the research literature; however, functional analysis also requires a high level of training and experience to design, conduct, and interpret results. Only licensed practitioners with the appropriate level of competence should conduct functional analysis and the risks, benefits, and resources available must be carefully considering and described to those consenting for behavioral assessment and treatment prior to initiation.*
Hypothesized functions of behavior	*Minimum elements:* *This section must include a description and situations of occurrence for each challenging behavior that will be targeted for decrease in this BSP along with the hypothesized function(s) of each behavior. This may be incorporated directly into the section on FBA as opposed to utilizing a separate section in the BSP.*

	<u>Note:</u> A hypothesis statement may be used to outline the function(s) of behavior(s). Hypothesized function(s) of behavior must correspond with what are generally accepted functions of operant behavior (attention, escape, tangible, and automatic).
Behaviors targeted for decrease	*<u>Minimum elements:</u>* *Include 1) each behavior that is targeted for decrease, 2) an objective operational definition for each behavior including examples and non-examples, and 3) the method(s) of measurement that will be used to track each behavior.* *<u>Note:</u> Subsequent to completion of the FBA and launching the BSP, data analysis through an appropriate graphical display is required for behaviors targeted for decrease.*
Behaviors targeted for increase (e.g. replacement and/or alternative and adaptive behaviors)	*<u>Minimum elements:</u>* *This section must include 1) each functionally equivalent replacement behavior(s) that will be targeted for acquisition, 2) an objective operational definition for each replacement behavior/behavior targeted for increase including examples and non-examples, and 3) the method(s) of measurement that will be used to track each.* *<u>Note:</u> Behaviors targeted for decrease should have a functionally equivalent replacement behavior (i.e. replacement behaviors corresponds to the hypothesized function(s) of behavior(s) it is to replace, though it is understood that it may not be possible to identify functionally equivalent replacement behaviors for all behaviors targeted for decrease at all times. Subsequent to completion of the FBA, data analysis through an appropriate graphical display is required for behaviors targeted for increase (e.g. replacement behaviors).* *There may be other behaviors that are targeted for increase as a part of the BSP that are not necessarily functionally equivalent replacement behaviors (e.g. alternative or adaptive behaviors such as tolerating delays or waiting); these must be included in this area with an operational definition and associated measurement indications as previously noted for replacement behaviors.*
Antecedent interventions	*<u>Minimum elements:</u>* *This section must be inclusive of individualized, evidence-based procedures and tactics that minimize the likelihood that challenging behavior occurs and promotes an environment in which the acquisition of the functionally equivalent replacement behaviors is more likely to occur. For example, tactics that modify or minimize setting events or motivating operations that are correlated with behavior, as well as tactics or procedures that directly addresses immediate antecedents or precursors. Include preventative strategies that describe environmental stimuli that should or should not be present and any de-escalation strategies that address pre-cursor behaviors.*
Consequence interventions	*<u>Minimum elements:</u>* *This area must be inclusive of individualized, detailed information as to how those that are implementing this plan will respond to behaviors targeted for decrease and behaviors targeted for increase when they occur. This area contains*

	procedures and tactics that are 1) evidence-based and clinically indicated in regard to the hypothesized function(s) of behavior(s) to minimize reinforcement of challenging behavior(s), 2) emphasize the least restrictive, most effective treatment model based on the person's needs, learning history, and level of severity/intensity of behaviors targeted for decrease and 3) promote the acquisition of replacement behaviors and behaviors targeted for increase via appropriate provision of reinforcement (e.g. consideration of the matching law, schedule of reinforcement, inclusion of preferences/known reinforcers to increase desired behavior(s), and expectations of learning environment and associated learning materials or teaching conditions) *<u>Note:</u> There must be clear justification for the use of any procedures in this area which would constitute a limit imposed on an assured right or "Restrictions on Freedoms of Everyday Life" and such procedures must be approved in accordance with Virginia Administrative Code 12VAC35-115-50 and 12VAC35-115-100. Restrictive components of a behavior support plan, such as restraint or time out, to address challenging behaviors that are an immediate danger may be utilized only after a licensed professional or licensed behavior analyst has conducted a detailed and systematic assessment, see 12VAC35-115-105. Behavioral Treatment Plans.*
Safety and Crisis Guidelines	*<u>Minimum elements:</u>* *This section is required only if severe or dangerous behavior requires the prescription of the use of restrictive components as denoted in the Human Right's Regulations such as restraint or time out, or if there is specialized safety equipment needed for an individual receiving or persons providing services (e.g. armguards to prevent injury from biting). If so, then this area must be included to include information as to any safety gear to be available when working with the individual, specific crisis protocols and/or indications as to where to obtain these protocols and/or any other safety precautions to promote both the safety of the individual and the safety of others in the environment. This section should also reference all known contraindications to the use of rime out or any form of restraint, including medical contraindications, see 12VAC35-115-110. Use of Seclusion, Restraint and Time Out. Additionally, describe objectively any topographies, intensities, and/or related negative outcomes of severe and dangerous behavior and the supports necessary to ensure the safety of the individual and others. Any prescription of emergency safety procedures (e.g. restraint or time out) must adhere to Human Rights guidelines (see below) and of the policy and procedures of the provider including continuous monitoring of the individual while in restraint or time out, criteria for release of the restraint or time out, and debriefing procedures. For intrusive or restrictive components, a monthly review of data (or more frequently, as needed) is required.* *<u>Note:</u> There must be clear justification for the use of any procedures in this area which would constitute a limit imposed on an assured right or "Restrictions on Freedoms of Everyday Life" and such procedures must be approved in accordance with Virginia Administrative Code 12VAC35-115-50 and 12VAC35-115-100. Restrictive components of a behavior support plan, such as restraint or time out, to address challenging behaviors that are an immediate danger*

	may be utilized only after a licensed professional or licensed behavior analyst has conducted a detailed and systematic assessment, see 12VAC35-115-105. Behavioral Treatment Plans. The documentation of approval and related signatures of the behavior treatment plan (behavior support plan) are required to be available for review by DBHDS Office of Licensing, Human Rights and any other quality review by DBHDS.
Plan for training	*Minimum elements:* *The BSP must include the proposed plan to train staff or others that will be implementing the BSP.* *Quality training consists of delivering information on staff expectations per the plan and data collection once it is developed, as well as providing opportunities for staff to practice skills that are to be performed when providing support to an individual (e.g. using a behavioral skills training model for staff training). Plan for training must include how often data will be obtained and reviewed by the behaviorist. The BSP will outline specifics on the plan of training to include how planning will be provided to key stakeholders, both initially and ongoing. When delivering training, the behaviorist must keep a record of those that have been trained on the BSP by the behaviorist. Training records will need to be submitted in WaMS for any annual authorization requests.*
Appropriate signatures	*Minimum elements:* *Informed consent must be obtained prior to the initiation of behavioral services, assessment and launch of the behavior plan, and when significant treatment updates occur. Consent must include individual and/or guardian's signature and contact information (guardian or Authorized Representative, where applicable). Signatures and associated dates are to be included on the behavior plan when it is initiated. Consent must be obtained prior to treatment procedures/protocols changes that involve the addition of a restrictive component.* *Note: There must be clear justification for the use of any procedures in this area which would constitute a limit imposed on an assured right or "Restrictions on Freedoms of Everyday Life" and such procedures must be approved in accordance with Virginia Administrative Code 12VAC35-115-50 and 12VAC35-115-100. Restrictive components of a behavior support plan, such as restraint or time out, to address challenging behaviors that are an immediate danger may be utilized only after a licensed professional or licensed behavior analyst has conducted a detailed and systematic assessment, see 12VAC35-115-105. Behavioral Treatment Plans. The documentation of approval and related signatures of the behavior treatment plan (behavior support plan) are required to be available for review by DBHDS Office of Licensing, Human Rights and any other quality review by DBHDS.*

Utilizing elements of positive behavior support in behavior support plans

While there are differing definitions on the term "positive behavior support"(PBS) in the extensive literature on the topic, the Association of Positive Behavior Support (n.d.) offers a definition of PBS as a set of research based strategies used to increase quality of life and decrease problem behavior by teaching new skills and making changes in a person's environment. Seminal works on PBS indicate its origins to be a synthesis of applied behavior analysis (ABA), the normalization and inclusion movement, and person-centered values (Carr, Dunlap, Horner, Koegel, Turnbull, Sailor, Anderson, Albin, Koegel, & Fox, 2002). One key researcher in the PBS movement has described PBS as "an approach that blends values about the rights of people with disabilities with a practical science about how learning and behavior change occur" (Horner, 2000, p. 97). A focus in many streams of quality PBS applications is the utilization of the science of ABA to modify environments to make problem behavior irrelevant, inefficient, and ineffective (Horner, 2000). As Horner (2000) notes, the PBS movement is deeply rooted in the science of behavior analysis, which offers thousands of research studies in the professional literature on the natural laws that govern behavior. Espousing the use of non-aversive behavior change techniques is an important component of early PBS works and should be incorporated into behavior support planning by all behaviorists (Horner, Dunlap, Koegel, Carr, Sailor, Anderson, Albin, & O'Neill, 1990). For historical context, prior to the full formalization of the larger PBS movement, the right to effective behavioral treatment had been well articulated in the behavioral literature, with these rights outlined as follows: treatment in a therapeutic environment, services with an overriding goal of personal welfare, behavioral treatment provided by professionals with appropriate education and experience, programming that teaches functional skills, treatment driven by assessment and ongoing evaluation, and utilization of the most effective and scientifically validated treatments available (Van Houten, Axelrod, Bailey, Favell, Foxx, Iwata, & Lovaas, 1988). This information is outlined to highlight for both newly minted behavioral providers (as well as those that have been practicing for many years) that the concepts of using the least restrictive treatment approach, avoiding unnecessary aversive interventions and/or restrictive procedures and instead promoting reinforcement based strategies that focus on establishing functionally equivalent replacement behaviors, and considering what is important to the individual in working towards increasing the quality of one's life are long established expectations for behavioral services. As it relates to incorporating positive behavior support concepts into behavior treatment plans, it is suggested that behavior support plans always address or include the following fundamental elements (at a minimum): 1) utilization of functional behavior assessment procedures to determine functions and conditions in which functions occur; 2) focus on promoting an environment in which the acquisition of functionally equivalent (replacement), or other desirable behaviors, can occur; 3) incorporation of interventions which correspond to the outcomes of functional assessment procedures (e.g. function based treatment) and consider needs, resources, and the individual's preferences; and 4) applying principles of behavior not only to address the individual's challenging behavior, but simultaneously to bolster the larger system of support for the individual and to improve quality of life in accordance with the individual's values (Carr et. al, 2002; Heineman, 2015).

The two primary credential and license (Board Certified Behavior Analyst®/BCBA® and Licensed Behavior Analyst) or endorsement (Positive Behavior Supports Facilitator/PBSF) that are providing therapeutic consultation behavioral services in Virginia have comprehensive standards of or scopes of practice and ethical codes, and though semantics may differ slightly across these, each aligns with the concepts noted above. As such, in behavior support planning for individuals receiving therapeutic consultation behavioral services through the DD waiver, it is expected that practitioners will be delivering services to Virginians that are congruent with their own practice standards, ethical codes, and regulations that govern their endorsement, credential, or license. This information can be found at the following websites:

https://www.bacb.com

https://www.dhp.virginia.gov/medicine/medicine_laws_regs.htm

http://www.personcenteredpractices.org/launch_vpbs.html

In addition, providers must be aware of and comply with the DBHDS Human Rights Regulations:

http://law.lis.virginia.gov/admincode/title12/agency35/chapter115/

Resources and References:

Association for Positive Behavior Support. (n.d.). *What is positive behavior support?* https://www.apbs.org/

Carr, E.G., Dunlap, G., Horner, R.H., Koegel, R.L., Turnbull, A.P., Sailor, W., Anderson, J.L., Albin, R.W., Koegel, L.K., & Fox, L. (2002). Positive behavior support: evolution of an applied science. *Journal of Positive Behavior Interventions, 4(1), 1-20.*

Heineman, M. (2015). Positive behavior support for individuals with behavior challenges. *Behavior Analysis in Practice 8(1),* 101-108.

Horner, R. H. (2000). Positive behavior supports. *Focus on Autism and Other Developmental Disabilities, 15(2), 97-105.*

Horner, R. H., Dunlap, G., Koegel, R. L., Carr, E. G., Sailor, W., Andeson, J., Albin, R.W., & O'Neill, R.E. (1990). Toward a technology of ''nonaversive'' behavior support. *Journal of the Association for Persons with Severe Handicaps, 15, 125–132*.

Positive Behavioral Interventions and Supports: https://www.pbis.org/

Van Houten, R., Axelrod, S., Bailey, J.S., Favell, J.E., Foxx, R.M., Iwata, B.A., & Lovaas, O.I. (1988). The right to effective behavioral treatment. *The Behavior Analyst*, *11(2), 11-114.*

Person centered practices in behavior support plans

Person centered thinking has been described as a set of value based skills that result in getting to know a person and then acting on what is learned (Center for Person Centered Practices, n.d.). Person centered thinking and values must be integrated into behavior support planning as the individualized preferences, needs, and strengths of the person receiving behavioral services are critical in learning about both what is important for the individual and to the individual in developing plans that will promote sustained behavior change and improved quality of life. It has been well established in the professional literature that behavior change tactics which take into consideration not only what is important for the person (e.g. decreasing challenging behavior), but also what is important to the person (e.g. acquiring new skills to express their desires) not only decreases problem behavior but can increase and maintain new ways of responding and promote habilitation (Durand & Carr, 1991).

Behaviorists utilize evidence and function-based interventions that are selected based upon functional behavior assessment (FBA) results to decrease challenging behaviors while simultaneously increasing desirable behaviors that promote habilitation and independence (Newcomb & Hagopian, 2018). Thorough FBA procedures can be considered inherently person centered in nature as the goal of FBA is to determine "why" the person is communicating with challenging behavior. Subsequently, function-based treatment can be considered person centered in nature in that it uses the results of FBA to minimize reinforcement of problem behavior and to strengthen appropriate alternative behavior such that the individual is less likely to engage in challenging behavior as they have learned new skills that get their wants and needs met. Though the "behavior modification" techniques of old were effective in reducing challenging behavior, such tactics relied on incorporating reinforcers or punishers to change behavior without a thorough understanding of the function of the target behavior(s) (Hanley, 2012). Relying on evidence-based FBA processes "dignifies the treatment development process by essentially 'asking' the person why he or she is in engaging in problem behavior prior to developing a treatment" (Hanley, 2012, p. 55). It is now established best practice in applied behavioral service delivery that those who are responsible for assessing challenging behavior and designing behavioral treatment packages should be utilizing empirically supported functional behavior assessment and function based treatment practices (Newcomb & Hagopian, 2018; Ala'i-Rosales, Cihon, Currier, Ferguson, Leaf, Leaf, McEachin, & Weinkauf, 2019).

There are a variety of person centered planning tools which are freely available on the internet and can be used as a part of initial assessment and treatment planning. Person-centered planning is also a requirement for individuals receiving waiver services as a part of the Individual Supports Plan (ISP) process and behaviorists that are billing therapeutic consultation behavioral services may request the individual's person centered plan from the individual's support coordinator. There are a plethora of interview-based and empirically validated preference or reinforcement assessment tools that are also freely available via a web search. Several examples are the Reinforcer Assessment for Individuals with Severe Disability (RAISD), single stimulus preference assessments, paired stimulus preference assessments, and multiple stimulus preference assessments without replacement, to name a few. In the context of determining what is most important to an individual, research

suggests the importance of empirically evaluating reported preferences from person centered plans (Green, Middleton, & Reid, 2000); validated empirical preference assessments are tools which behaviorists should utilize to learn more about what is important to an individual in behavior support planning. Resources on person centered planning and preference or reinforcer assessment tools are available in the resources and references area below.

Resources and References:

Ala'i-Rosales, S., Cihon, J.H., Currier, T.D.R, Ferguson, J.L., Leaf, J.B., Leaf, R, McEachin, J., & Weinkauf, S.M. (2019). The Big Four: Functional Assessment Research Informs Preventative Behavior Analysis. *Behavior Analysis in Practice, 12(1), 222-234.*

Cornell University ILR School Employment and Disability Institute: http://www.personcenteredplanning.org/

Durand, V. M., & Carr, E. G. (1991). Functional communication training to reduce challenging behavior: Maintenance and application in new settings. *Journal of Applied Behavior Analysis, 24, 251-264.*

Hanley, G.P. (2012). Functional assessment of problem behavior: dispelling myths, overcoming implementation obstacles, and developing new lore. *Behavior Analysis in Practice, 5(1), 54-72.*

Green, C.W., Middleton, S. G., Reid, D.H. (2000). Embedded evaluation of preferences sampled from person-centered plans for people with profound multiple disabilities. *Journal of Applied Behavior Analysis, 33*(4), 639-642.

Kennedy Krieger Institute, Neurobehavioral Unit: Resources for Practitioners https://www.kennedykrieger.org/patient-care/centers-and-programs/neurobehavioral-unit-nbu

Newcomb, E.T. & Hagopian, L.P. (2018) Treatment of severe problem behaviour in children with autism spectrum disorder and intellectual disabilities, *International Review of Psychiatry, 30*(1), 96-109, DOI: 10.1080/09540261.2018.1435513

The Learning Community for Person Centered Practices: https://tlcpcp.com/

Virginia Commonwealth University Center for Person Centered Practices (n.d.) *Person centered thinking.* http://www.personcenteredpractices.org/launch_pct.html

Trauma Informed Care in Behavior Support Planning

The concept of "trauma informed care" has become well known in education, health, and human services fields. One conceptualization suggests that trauma informed care is a recognition among service providers that there is the possibility for trauma related presentations with persons served and that an overall commitment is taken to reducing the likelihood that persons are re-traumatized through treatment (Keesler, 2014). The Substance Abuse and Mental Health Services Administration further offers a trauma informed conceptualization as follows: "[a] program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist retraumatization." (SAMSHA, 2014, p. 9). Sadly, the DD population remains at a much higher likelihood than the general population for experiencing traumatic experiences of abuse, neglect, or exploitation. A 2012 Spectrum Institute study indicated that 70 percent of individuals with I/DD interviewed indicated they had been sexually, physically, or financially abused, and 90 percent of those individuals indicated that this abuse was ongoing (Baladerian, Coleman, & Stream, 2013). It is important for behavioral providers to be aware of such statistics when providing services to a vulnerable population, in particular one in which many individuals possess limited communicative skills. Such statistics suggest that it is more likely than not that those individuals that are receiving therapeutic consultation behavioral services have contacted traumatic experiences over the course of their lives, which may manifest in their overt behavioral repertoire. In children, repeated exposure to trauma can alter the child's psychobiological development and influence overt behavior; the neurological processes of children that experience complex trauma may be significantly impaired and result in changes in emotional self-regulation and responses to environmental stimuli (Ko, Ford, Kassam-Adams, Berkowitz, Wilson, Wong, Brymer, Layne, 2008). Regardless of one's age, significant or repeated exposure to traumatic events become a part of an individual's learning history and can shape an individual's behavioral patterns. Co-occurring symptoms or formal diagnoses of post-traumatic stress disorder or other mental health disorders are not uncommon among persons that have experienced trauma (Keesler, 2014). It is critical to thoroughly examine an individual's learning history, including their known trauma history, when completing an FBA. Subsequently, incorporating informed interventions in an individualized behavior support plan is a necessity.

At this time, there is unfortunately scant peer reviewed, empirical literature on trauma informed care practices specific to behavior support planning derived from FBA processes. Notably, however, the Center on Positive Behavior Supports and Interventions (PBIS) has provided practice guidelines on integrating a trauma informed approach within a PBIS framework in educational settings (*Note: PBIS is a three tiered model utilized in schools to achieve academic and social success which is rooted in behavioral research;* see Horner, Sugai, & Lewis, 2020). Though PBIS operates at a school or district-wide educational level (and also includes a tier for individualized support for the most at risk students), the indications in recent PBIS practice guidelines on trauma informed care draws parallels between approaches, the following of which can be certainly applied at an individual behavior support planning level in non-educational settings: predictable, safe, and positive

environments promote healing and acquisition of new skills (Eber, Barrett, Scheel, Flammini, & Pohlman, 2020). With such a conceptualization in mind, there are some general suggestions offered as it relates to adopting a trauma informed care approach in functional behavior assessment, behavior support planning, and the delivery of behavioral services. As a part of the initial functional assessment process, behaviorists pay close attention to details about a person's physiological and psychiatric conditions, medication regimens, the aspect of the environment in which the person lives and interactions with others, as well as their learning history; this is part and parcel of a robust ecological assessment in the FBA process and can provide very useful information in beginning to formulate hypotheses as to what variables are contributing to and maintaining behavioral challenges. As a part of this assessment process, it is suggested that behaviorists also pay close attention to any apparent trauma history, and when appropriate ask follow up questions to learn about past or current events that may be impactful to the way the individual interacts with their world. If such information is garnered during the FBA process, it must be incorporated into the body of the behavior support plan both via individualized interventions that are designed specifically for the needs of the individual, as well as such that persons working to support the individual have clear awareness of traumatic experiences the individual has encountered. Such information should also be outlined in trainings presented as a part of ongoing psycho-education for families and staff members. When it is learned that there is a trauma history, some behaviorists may find it useful to conceptualize trauma in behavioral terms, such as conceptualizing trauma as an aversive event and to assume that there is a strong likelihood that the stimuli associated with traumatic experiences have become conditioned punishers for the individual. Behaviorists are trained to understand the naturally occurring patterns of behavior evoked surrounding known punishers, in particular escape or avoidance behavior, and are aware that in some situations these behavioral patterns may present with challenging behavior in the form of emotional or aggressive reactions (Cooper, Heron, & Heward, 2007). As it is important to consider the immediate consequence of challenging behavior, it is also important to consider the entirety of learning history as the sum of one's past experiences can influence behaviors that are used later in life (Kolu, N.D.). By learning about traumatic experiences in the functional assessment process, behaviorists can adopt trauma informed practices into behavior support plans and associated stakeholder training. As it relates to trauma informed practices in behavior support planning, a few basic examples may be as follows: providing as many opportunities as possible to contact positive reinforcers on a non-contingent basis, incorporating proactive teaching strategies for replacement behaviors, utilizing strategies that do not replicate a known traumatic experience (including in crisis or safety related strategies), and utilizing antecedent modification tactics to reduce the presence of discriminative stimuli in the environment which are associated with highly traumatic experiences. Again, it cannot be overemphasized that selected behavior change tactics should be clinically indicated based upon the specific needs of the person and function(s) of behavior(s) as determined through robust FBA procedures. In non-behavioral terms, and in particular as it relates to staff and key stakeholder training on behavior support plans, it is important to build in as much opportunity for choice as possible, provide freedom to encounter experiences that are positive and valued to the person without strings attached, to train staff to work as a partner as opposed to an authority figure, to be aware of the known "triggers" surrounding traumatic events and the known trauma history, to provide information on how staff can build rapport with an individual, to proactively plan for therapeutic safety and crisis interventions that are as non-

restrictive and non-aversive as possible, to include information on known traumatic experiences in the content of the plan and tailor interventions that are mindful of these experiences, and of course to treat all individuals with the utmost dignity and respect at all times.

References and resources:

Adverse Childhood Experiences Study information: https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html

American Psychological Association Division 56, Trauma Psychology. https://www.apatraumadivision.org/

Baladerian, N.J., Coleman, T.F., & Stream, J. (2013). Abuse of people with disabilities: victims and their families speak out. *Spectrum Institute Disability and Abuse Project.* Retrieved from: http://disability-abuse.com/survey/survey-report.pdf

Cooper, J., Heron, T. & Heward, W., 2007. *Applied Behavior Analysis*. 2nd ed. Upper Saddle River, NJ: Pearson.

Eber, L, Barrett, S., Scheel, N., Flammini, A. & Pohlman, K. Integrating a trauma-informed approach within a PBIS framework. *Center on PBIS.* Retrieved from: https://www.pbis.org/resource/integrating-a-trauma-informed-approach-within-a-pbis-framework

Horner, R.H., Sugai, G., & Lewis, T. (2020). Is school wide positive behavioral interventions and supports (PBIS) an evidence based practice? *Center on PBIS.* Retrieved from: https://www.pbis.org/resource/is-school-wide-positive-behavior-support-an-evidence-based-practice

Keesler, J.M. (2014). Trauma through the lens of service coordinators: exploring their awareness of adverse life events among adults with intellectual disabilities. *Advances in Mental Health and Intellectual Disabilities, 8(3), 151-164.*

Ko, S.J., Ford, J.D., Kassam-Adams, N., Berkowitz, S.J., Wilson, C., Wong, M. Brymer, M.J., & Layne, C.M. (2008). Creating trauma informed systems: child welfare, education, first responders, health care, and juvenile justice. *Professional Psychology: Research and Practice, 39(4), 396-404.*

Kolu, C. (n.d.) *Interview with Camille Kolu: trauma informed behavior analysis helps trusted teams make informed care decisions*; *Awake Labs.* https://awakelabs.com/trauma-informed-behavior-analysis-autism/

Sciaraffa, M. A., Zeanah, P. D., & Zeanah, C. H. (2018). Understanding and promoting resilience in the context of adverse childhood experiences. Early Childhood Education Journal, 46(3), 343-353.

Substance Abuse and Mental Health Services Administration. (2014). SAMHSA's concept of trauma and guidance for a trauma- informed approach (HHS Publication No. 14-4884). Retrieved from https://store.samhsa.gov/system/files/ sma14- 4884.pdf.

In addition, providers must be aware of and comply with the DBHDS Human Rights Regulations:

https://law.lis.virginia.gov/admincode/title12/agency35/chapter115/section175/

https://law.lis.virginia.gov/admincode/title12/agency35/chapter115/section230/

Timelines and required documentation for therapeutic consultation behavioral services authorizations

Note: The table below provides a summary visual. Please see the full text of the regulations that govern this service at: 12 VAC 30-122-550

Authorization Type	*Timeframe*	*Required documentation for authorization*
Initial Authorization	Up to 180 days	• Part V must outline the following: ○ that a Functional Behavioral Assessment (FBA) will be conducted ○ that a BSP will be created ○ the plan for data collection during this period
Second authorization	Post 180 days of the initial authorization period until the ISP annual date	• Behavior Support Plan • FBA (the FBA may be within the BSP or a separate document). • Any baseline data or treatment data collected used in formulating the plan • Part V must outline the following: ○ Request for or description of training for stakeholders must be included and parallel what is included in the training section of the BSP. ○ Measurable benchmarks for behaviors targeted for increase and decrease in the BSP, which must be included in the " I no longer want (or)/need supports when…" area of the Part V
ISP Update (Annual renewal or when needed)	Annual ISP date to annual ISP date	• Graphical displays with progress summary covering at least the current review period. • Current BSP • Current FBA (FBA can be incorporated into the BSP or on a separate document) ○ In preparation for the shared planning meeting, the most recent FBA and treatment data must be reviewed by the behaviorist. A reference of this review and the behaviorist's determination of the continued validity or need for re-assessment must be included in the FBA. See Part V requirements below if re-assessment is determined. • Documentation of any training completed within the timeframe of the most recent review period • Part V must outline the following: ○ Request for or description of training for stakeholders must be included and parallel what is included in the training section of the BSP. ○ *If the behaviorist determines re-assessment is needed, request re-assessment in Part V. If behaviorist determines previous FBA is still valid, re-assessment does not need to be include in the Part V.*