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SUBJECT:

Guidance for Conducting Functional Behavioral Assessments in the Development of Treatment Plans for Services Delivered to Children with Behavioral Health Needs Compounded by Developmental Disorders

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SCOPE:

This bulletin applies to Mental Health/Mental Retardation (MH/MR) Administrators, providers of behavioral health rehabilitation (BHR) services in both the fee-for-service and the managed care delivery systems, CASSP Coordinators, and HealthChoices Behavioral Health Managed Care Organizations (BH-MCOs).

PURPOSE:

The purpose of this bulletin is to provide guidance for conducting functional behavioral assessments to be used in the development of treatment plans for services delivered to children with behavioral health needs compounded by developmental disorders, such as autistic disorder and other pervasive developmental disorders.

BACKGROUND:

The cornerstone to delivering BHR services to all children and adolescents is an individualized treatment plan designed to meet the needs of the child or adolescent. Using a functional behavioral assessment (FBA) to determine the treatment approach and ultimately develop a treatment plan is currently the standard of care for treating children and adolescents with behavioral health needs compounded by developmental disorders, such as autistic disorder and other pervasive developmental disorders, who present with challenging behaviors. The purpose of the FBA is to attempt to understand, from multiple perspectives, the variables that surround the reasons for the occurrence of behavior(s). As such, an FBA enables the treating professionals to develop a treatment plan that is individualized to meet the needs of each child or adolescent.

To support the enhancement of service delivery consistent with the existing standard of care in the field, staff in the Office of Developmental Programs Bureau of Autism Services (BAS), as of January 1, 2009, have provided training on the use of the FBA to almost 2000 Behavior Specialist Consultants (BSCs) as well as over 800 Therapeutic Staff Support (TSS) workers in their role in the FBA process. BAS staff have also trained designated professionals in provider

agencies and Behavioral Health Managed Care Organizations (BH-MCO) who will be able to provide ongoing training to new staff.

The BH-MCOs have begun to credential BSCs who have completed the training conducted by BAS or who are Board Certified Behavior Analysts. In order to qualify for credentialing, a BSC must complete the training provided by BAS and demonstrate competence in conducting the FBA or complete one of the Board Certified Behavior Analyst (BCBA) credential programs offered by a university.

FBA's conducted by credentialed BSCs will be available for children and adolescents with behavioral health needs compounded by developmental disorders, such as autistic disorder and other pervasive developmental disorders, in both the fee-for-service delivery system and in HealthChoices beginning January 1, 2009. Physicians and licensed psychologists who conduct evaluations for this population of children should know about the availability of an FBA when prescribing BHR services. In HealthChoices, provider network training will educate providers about the FBA and the need to monitor services to ensure interventions are achieving the desired outcomes. When an FBA is recommended as needed to assist in formulating the treatment plan for a child, the prescription and authorization will include sufficient hours for a credentialed BSC and TSS (as needed) to complete the evaluation, in addition other medically necessary services to meet the child's needs. The prescription and hours recommended for on-going treatment should be based on the FBA and could be requested as an addendum to the initial authorization or other established procedure. A family may choose not to have an FBA conducted for their child. A request for BHR services may not be denied because an FBA was not conducted.

DISCUSSION:

An FBA should be conducted as early in the treatment planning process as possible, at the beginning of service delivery or before the current authorization period expires if there is significant change in behavior, or deterioration in behavior that may indicate the need for a different level of care, such as residential treatment, or otherwise a need to plan a new treatment approach. The interventions and hours of ongoing treatment recommended from the FBA form the basis for developing the ongoing treatment plan and in formulating a crisis intervention plan.

CONDUCTING THE FBA

The initial FBA will take an average of twelve to fifteen hours over four to six weeks to complete, but could take longer, depending on the complexity of the child's needs. The length of subsequent FBA's or updates to an FBA will similarly depend on the child's needs and the circumstances that prompted the need for the new or updated FBA. During the FBA, TSS may be needed to assist the BSC with observations and interventions at the most problematic times of the day as identified by the parent or other caregiver. The role of the TSS worker in the FBA could include, for example, implementing basic interventions such as communication strategies (verbal behavior or discrete trial training) at the direction of the BSC or using a schedule to signal transitions while observing, noting and intervening to deescalate challenging behaviors. For example, for a preschooler who has no or limited verbal communication and

engages in aggressive behaviors or self-injury during transitions from school to home, the TSS worker could use a picture schedule to make the transition more predictable and to schedule attention with a parent (i.e., parent is trained to provide attention at a specific interval before the child has a behavioral episode).

An FBA includes indirect and direct methods of information gathering or data collection to identify those variables that may be maintaining, promoting, or increasing behavior.

- Indirect methods of data collection can include, but are not limited to, interviews with parents and other caregivers, teachers, daycare providers and other persons in the child's life; questionnaires completed by persons in the child's life; and record reviews.
- Direct methods of data collection typically include direct observation and are:
 - important to confirm or deny information gathered from sources;
 - integral in obtaining a baseline or starting point of the behavior; and
 - effective to monitor and evaluate the effect of the treatment plan on the behavior.

*** Data should be collected from many sources (e.g., parents and other caregivers, teachers, others in the child's life) using various methods (e.g., interviews, questionnaires) across many settings and activities.*

Data collection should never solely be a count of how often the behavior occurs. Instead, information gathered through the FBA identifies the variables that are important to understanding the behavior:

- The preceding setting events that may affect behavior (e.g., medication changes, fight with a family member before leaving the house, room temperature).
- The antecedents that may predict behavior (e.g., non-preferred activity, harsh tone of voice, abrupt change in schedule).
- Lack of necessary skills in particular environments (e.g., communication skills, prerequisite writing skills, coping skills needed for waiting).
- Consequences that may reinforce behavior (e.g., parental attention, removing child from the situation).
- The function or purpose of the behavior.

Above all, determining the function or the reason for the behavior provides the catalyst for the treatment plan. Research has proven that a majority of behavior serves one or both of the following functions:

- To obtain something (e.g., attention, activity, sensory stimulation).
- To escape something (e.g., attention, activity, sensory stimulation).

During the FBA the BSC analyzes the information gathered regarding the variables that influence the child's behavior. The end result of the FBA is to identify the function of the behavior to ensure that the function is met for the child in a more appropriate, accepted, efficient, and effective manner. For instance, if a child is hitting his or her mother when they are in the car, it is crucial to identify what it is about the car ride that seems to promote the

behavior. A child may be engaging in this behavior to escape a non-preferred activity (riding in the car), but has no way of communicating that to the mother, or the car ride may be over-stimulating for the child. One behavior may serve several functions, in which case, addressing both functions is important when developing the treatment plan.

USING THE FBA TO DEVELOP A TREATMENT PLAN

At the heart of the treatment plan is addressing how to support the child to get the function(s) met, given what is learned through the FBA about the child's behavior and the variables influencing it. All of the components gathered through indirect and direct methods of information gathering drive development of the treatment plan used by parents, caregivers, teachers, behavioral health staff, and others to support the child in a way that is respectful and dignified.

Understanding all variables (including function) that maintain, promote, or increase a behavior helps determine what components of the treatment plan that need to be eliminated, presented, or maintained to facilitate positive behavior in the future. Each treatment plan should include all of the goals and strategies that will address the short-term and long-term needs of the child.

Goals should be written clearly, to identify:

- The condition under which the appropriate behavior will occur.
- The definition of the appropriate or inappropriate behavior.
- The criteria for mastery of the goal.

Strategies are directed to the variables contributing to the child's behavior, listed above, as determined through the FBA. Strategies should include:

- Setting event strategies are those variables that may be a bit more difficult to change, but warrant a close look to see what may be eliminated or added to the child's day to decrease problem behavior. For instance, if the child consistently comes to school hungry because he or she refuses to eat in the morning after taking medications that upset his stomach, can the teacher give him or her a granola bar first thing upon arriving at school?
- Antecedent strategies such as someone changing his or her tone of voice when talking to the child, providing the child with a choice of activities, using a schedule to prompt changes in the child's daily activities.
- Strategies to address the child's lack of necessary skills are of utmost importance. For instance, if the child is continually engaging in self-injurious behavior at school and the FBA identified that it is when the child is sitting for more than a half-hour, the treatment plan should identify what can be done to help the child achieve a break in a manner that protects the child's safety and is acceptable in that environment. Teaching an alternative or replacement behavior that is just as effective, efficient, and relevant as the behavior is crucial. In this example, teaching the child to give a card that says "break" to

his or her teacher when the child is tired and unable to cope with more sitting would be appropriate.

- Consequence strategies could include the way that someone responds to the behavior to reinforce appropriate behaviors (e.g., replacement skills) or strategies to decrease inappropriate behaviors (e.g., redirecting the child to use the replacement skill while ignoring the problem behavior), or both.
- Lifestyle strategies that may increase the child's overall quality of life by addressing variables such as social networks, health and safety, self-determination, inclusion, and satisfaction.

To ensure that the strategies developed in the treatment plan maintain throughout the child's daily life, specific strategies to sustain support should also be developed. For example, the team should address what it will do to ensure that the treatment plan will be used across settings and over time, and how new persons in the child's life will know about and be able to use the treatment plan. The team (BSC, parents, school, day care, etc.) will need to identify responsible persons who will keep all persons in the child's life abreast of the current strategies and changes to the treatment plan, and also train all of those persons on specific strategies to ensure consistent support across all settings. The treatment plan will document who is responsible for interventions in each setting.

EXAMPLE:

***Goal:** Donnie will decrease his inappropriate comments (e.g., "you are the worst mother in the world," "you need to get a life, old lady," "I hate your *** guts!") directed to his mother during times in which he needs his mother's assistance (prior to getting dressed, prior to going to the bathroom, or prior to taking his medicine) or attention (when he is doing an activity independent of his mother) by using a schedule to predict attention (provide attention before a behavioral episode) or a cue card to ask for help. He will decrease this behavior from 20 per hour to 5 per hour this quarter.*

Antecedent/Setting Event Strategies	Alternative Skills Instruction	Consequence Strategies	Maintaining Supports
<p>When Donnie's mother comes home from work, she will sit and talk about his day and develop a nightly schedule</p> <p>Schedule – develop visual schedule of what activities will occur in what sequence</p>	<p>Teach Donnie to ask for help: "I need you to help me _____" cue card</p> <p>BSC will teach child and TSS who will prompt if needed</p>	<p>Parents will ignore behavior</p> <p>Parents will remind Donnie of scheduled activities</p> <p>Respond to appropriate ways to ask for help (reinforcement - all persons involved, parents, school, TSS, etc.)</p>	<p>Parents and Donnie will develop a contractual agreement (agreement with child to try these interventions) that was amended to include: increased time alone, increase in novel activities</p>

THE CRISIS INTERVENTION PLAN

A crisis intervention plan is a separate document that is attached to the treatment plan that specifies what actions to be taken in the event that a child engages in behavior that becomes a threat to the safety of self or others or to valuable property. For instance, if a new TSS worker forgets that the child's treatment plan states that a verbal reminder of appropriate behaviors before getting in the car is needed, this may provoke behavior such as severe aggression to the driver while the car is in motion that cannot be stopped with verbal redirection and thus, warrants implementation of a crisis intervention plan.

The crisis intervention plan developed for the child should address the following stages (before, during and after the crisis):

Planning for the Crisis

The plan should outline:

- What will be done to ensure safety of all involved?
- What procedures (intervention to address behavior) will deescalate the challenging behaviors?
- What procedures will require changes to the physical area (e.g., clear room, add pads)?
- What precursor behaviors will alert the staff to a potential crisis and prompt staff to use de-escalation techniques to avoid a crisis event?
- What timing factors will eliminate risk of injury (e.g. moving others out of the room before someone is hurt rather than after)?
- How many people will be needed to put the plan into play?
- How staff will be signaled to assist other staff?
- What behaviors will alert family, teachers, and staff that the individual is safe and the crisis is over?

Determine need for training:

- General implementation of the crisis plan – who needs to be trained (parents, bus driver, TSS, BSC, teachers aides) to address specific behaviors in specific locations.

During the Crisis Event

Determine the "stage" of the crisis event (escalation, peak, or recovery) and implement the crisis plan developed (following the guidelines above). For example: escalation may start with yelling, pacing, and picking skin and then move to peak with head banging and biting others. Recovery may mean he or she then sits down after given a choice of a break or a walk and relaxes and simply cries. The planning for the crisis event will be different for each child.

After the Crisis Event

- Identify how the child resumes routine tasks and activities of the day and what supports are needed.

- Identify the need for follow-up treatment to be identified and who will ensure the follow-up occurs:
 - Identify how crisis procedures will be documented such as in an incident report and recorded in the clinical record.
 - Identify how the response to the crisis will be evaluated. After the crisis determine who and when to convene a review to determine if the crisis intervention worked or if the crisis plan should be modified.
 - Identify when the Team will convene to revisit the Crisis Intervention Plan in an effort to avoid crisis in the future (a crisis usually results in a change or adjustment to the treatment plan).

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

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