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Embracing Behavioral Supports and Meaningful Applications

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Positive Approaches Foreword

"In essence, Positive Approaches is a worldview, in which all individuals are treated with dignity and respect, in which all are entitled to Everyday Lives."

—Beth Barol, 1996

The first issue of the Positive Approaches Journal was published in the summer of 1996 and focused on positive approaches in four main domains, environment, communication, assessment and "hanging in there." In the 26 years since that first edition, we have rebalanced our system so that most people are served in community versus facility settings. During this time, we have also witnessed significant advances in our understanding of trauma, brain development, genetics and treatment options. In spite of these advances, the lessons from that first edition of the journal still hold relevance for us today because, as a system, we still face challenges in supporting people with co-occurring intellectual or developmental disability and a serious mental illness to live Everyday Lives.

As our service systems continue to move away from institutional and congregate care and toward supporting people to be fully engaged in their communities, the need to revive the Positive Approaches Journal became clear to us. People who have dual diagnoses face some of the greatest challenges for true inclusion and being connected with their communities. We need to work together to develop best practices and appropriate services and supports. The

Positive Approaches Journal is part of a broad effort to build this capacity and support best practice in service delivery for people with dual diagnosis. The Journal will also allow us to share, communicate and collaborate as we address this very important issue.

We are eager for the submissions that will come from practitioners and theorists here in Pennsylvania that will drive innovation at all levels in our service systems. It is truly very exciting to begin publishing the Positive Approaches Journal again, and it is with great pleasure that we present to you Volume 10, Issue 2.

Kristin Ahrens
Deputy
Secretary

Office of Developmental Programs

Kristen Houser
Deputy Secretary

Office of Mental Health and Substance Abuse Services

Positive Approaches Journal Mission Statement

To improve lives by increasing capacity to provide supports and services to individuals with mental health and behavioral challenges, intellectual disabilities, autism and other developmental disabilities, using the guiding principles of Everyday Lives and the Recovery Movement.

Through case studies, articles, interviews, and related academic sources, Positive Approaches Journal will strive to feature resources, observations, and advancements that are relevant and timely to professionals and supporters.

Positive Approaches Journal Editorial Board

Introduction

If there's one thing we've learned in the past year, it's the value of being able to pivot. Our routines have been ransacked, whether we're providing support services in our jobs or planning a family gathering. Day by day, we evaluate the risks and benefits of any activity involving an encounter with others and make choices about social distance, masks, and using hand sanitizer. The restrictions have encouraged us to develop creative ways to take part in the world around us. Meeting in parks, virtual breakout rooms, or under patio lights by a firepit is now commonplace. Flexibility once praised primarily for people in creative endeavors, has become a survival strategy. And those who have mastered the ability to adapt quickly have thrived in spite of the obstacles.

Positive Behavioral Support, when done well, merges not only evidence-based practices but also ones that are flexible and creative. All humans use behaviors that work for them. Behavior specialists work like detectives uncovering clues and solving the puzzle to determine the functions of behavior. Each plan is unique and individualized, exploring not only observable consequences but also past trauma, environment, and genetics.

Articles in this issue encourage us to focus on merging silos of mental and physical health and incorporating biomedical and socio-environmental influences which all play into how a person behaves. No longer limited to practices like discrete trial training and aprons filled with M&M's, Positive Behavioral Support has proven effective in a variety of messy settings where challenging behaviors are likely to be triggered, like fast-food restaurants, playgrounds, job sites, and people's homes. We've learned that behavioral approaches, once thought to be effective only with specific populations of people with diagnoses like autism or intellectual disability are

effective for everyone, especially when developing plans with people who require complex mental health support. Creating multidisciplinary teams with a variety of stakeholders who like and admire the person needing support helps to promote a positive outcome and ensures simplicity and ease of administering a plan that works for everyone.

If this work inspires you, check out The Home and Community Positive Behavior Support (HCPBS) Network of the Association of Positive Behavior Support. HCPBS is a nonprofit organization that is dedicated to expanding and enhancing the application of positive behavior support principles across home and community settings, contexts, and the lifespan for people with behavioral challenges (including intellectual and developmental disabilities, mental health diagnoses, and seniors who require memory care and other related services) and the systems who support them. The HCPBS website (**www.hcpbs.org**) is loaded with practical resources, videos, stories of people who have been helped, and a treasure trove of evidence-based practices and research.

Molly Dellinger-Wray, MS Ed

Home and Community Positive Behavior Support Network

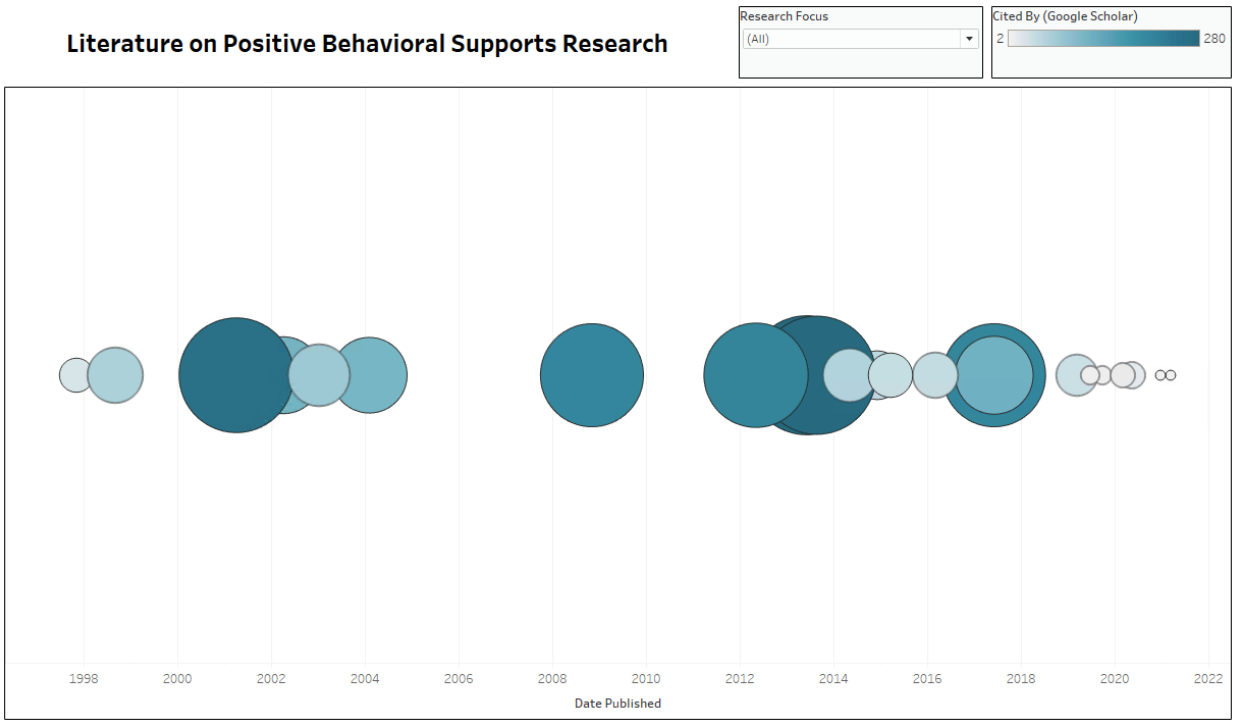
Partnership for People with Disabilities at Virginia Commonwealth University

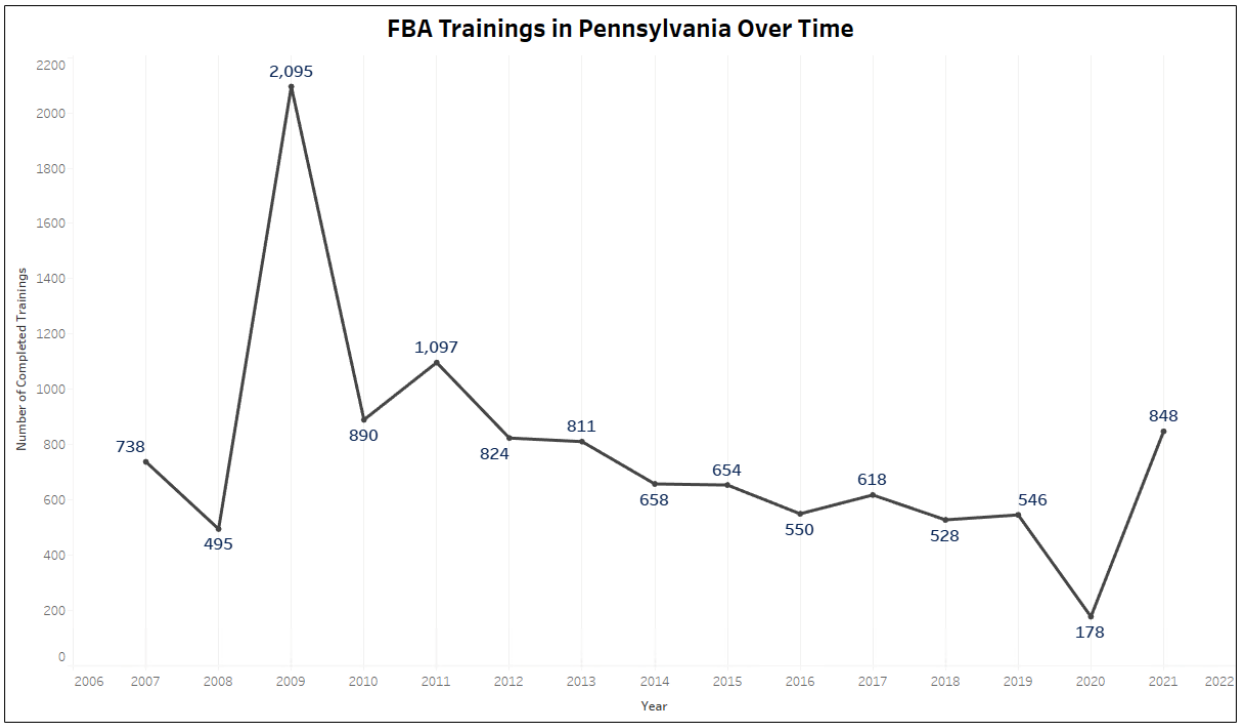
Data Discoveries Introduction

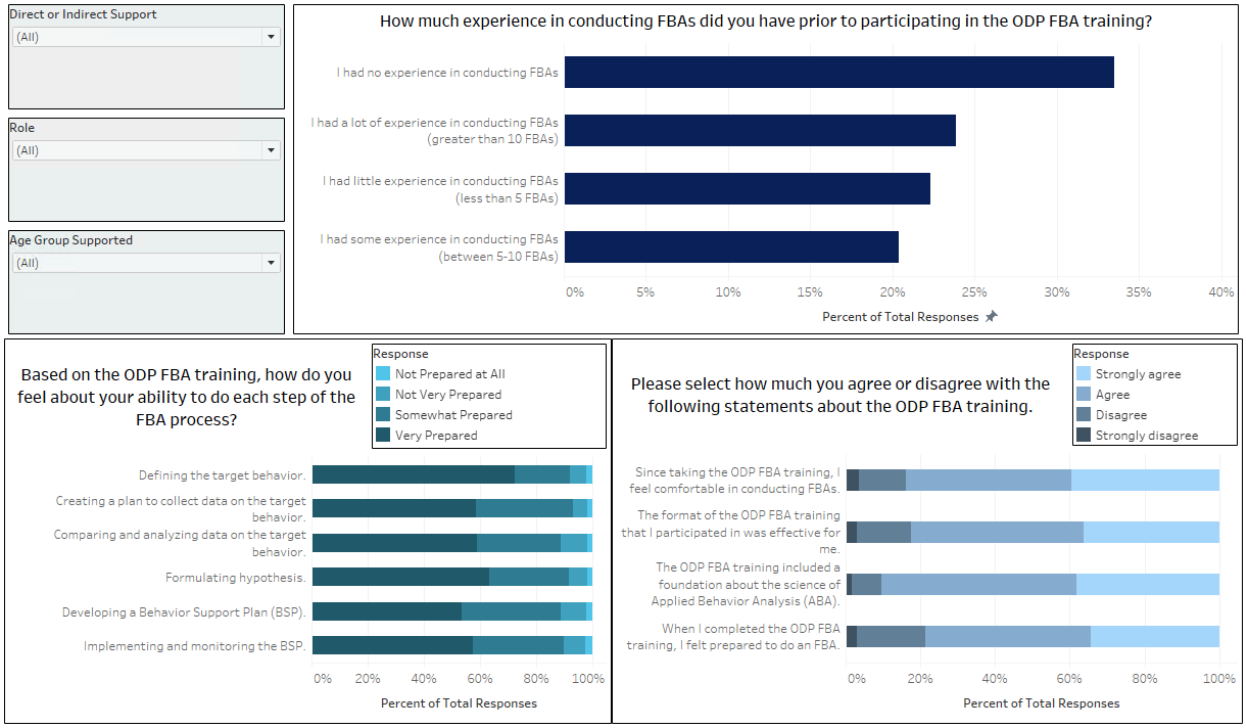
Positive Behavioral Supports (PBS) include a series of strategies for supporting individuals to improve quality of life and decrease challenging behaviors through evidence-based methods. PBS can be used in a variety of contexts like schools, homes, and communities.[1] While often described and implemented in disability populations like those with developmental disabilities or autism spectrum disorder (ASD)[2],[2] PBS has been used in a wide array of populations including those with childhood obesity[3] and an acquired brain injury.[4,5] One of the core principles of PBS is the Assessment of Contexts and Functions.[6] Assessment is critical in PBS to track patterns in when, how, and within what context(s) a behavior occurs to implement appropriate supports to improve individual quality of life. Assessments can take many forms in PBS including "…record reviews, interviews, and observations".[6] A Functional Behavior Assessment (FBA) is one example of a process that can gather and measure data surrounding a behavior that is occurring and identify variables that may be impacting the cause and effect of the behavior.[7] The goal of an FBA as part of PBS is to assess and replace challenging behaviors. Pennsylvania, through efforts of the Office of Developmental Programs (ODP), has been propelling strategies to support providers, across the service system and lifespan, in execution of FBAs as well as the development of a treatment or behavior support plan that can be used across settings through an FBA training. The ODP FBA training has been delivered in-person and via a DVD and has recently been upgraded to be an interactive, self-paced module online format that is widely accessible through the MyODP web platform.

The data dashboard below shows information about PBS and FBAs from several data sources. The first tab, 'Positive Behavioral Supports in Publications' shows the use of PBS in various

populations that have been published in academic, peer-reviewed journals through a search of scholarly journal databases for the phrase “positive behavior supports”. Click on a circle and you will be directed to the full text of the PBS articles. The size of the circle represents the number of other research articles citing that article, which is sometimes referred to as the impact of the article (e.g, the bigger the circle, the more impact or the more others have cited the article). To learn more about implementation of FBA training and practice in in Pennsylvania, click on: ‘FBA Training in Pennsylvania Over Time’ to view a timeline of training in FBA delivered in Pennsylvania by ODP FBA training. You can also learn about ‘Provider Perceptions of FBAs’ to view responses to a 2017 survey conducted by ODP and the Autism Services, Education, Resources, & Training Collaborative (ASERT) to gather opinions and perspectives about the ODP FBA training content and process. Use the filters to view responses by provider type, role function, and ages of individuals supported.







Data Discoveries Conclusion

For more resources and training to learn more about PBS, visit the Home and Community

Positive Behavior Support Network (HCPBS) website (**www.hcpbs.org/**). HCBPS is a clearinghouse of resources, webinars, literature, and other information focused on the application of PBS in home and community-based settings. For more information about the web based ODP FBA training, visit: **https://www.myodp.org/enrol/index.php?id=1644**. For more resources about FBAs from ASERT visit: **https://paautism.org/resource/functional-behavioral-assessment-student-education/**.

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Common Misconceptions About Behavioral Support – Debunked!

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Office of Developmental Programs Unified Clinical Team

Abstract

Behavioral support is often misunderstood, even while it provides a critical approach in supporting someone who may be using behaviors that interfere with optimal functioning and are challenging for supporters to understand. Applied research has provided the field with a plethora of evidence that this approach is an important consideration in treatment. The intent of this article is to provide accurate information about the behavioral approach as it applies to supporting people across the lifespan, who have varying disabilities, and work, live, and play in many settings and environments. The following misconceptions from the field will be reviewed:

- **Misconception #1:** Behavioral support only works for people with autism and certainly is not effective for people with mental illness.
- **Misconception #2:** Behavioral support is the only treatment modality that will address challenging or problematic behavior.
- **Misconception #3:** The more complex a person's needs are, the more behavioral support is required.
- **Misconception #4:** Behavioral support is primarily focusing on developing rewards as reinforcement for the person to decrease their challenging or problematic behavior.

- **Misconception #5:** There is one right way to conduct a Functional Behavioral Assessment (FBA).

- **Misconception #6:** Behavioral support and therapy are the same.

Misconception #1: Behavioral support only works for people with autism and certainly is not effective for people with mental illness.

Research has established behavioral interventions as an effective treatment strategy for people with autism; however, that does not mean behavioral supports and interventions should be limited to those diagnosed with autism. Behavioral supports include the development and implementation of behavioral interventions that are grounded in FBA across diagnoses.

The connection between behavioral support and mental illness is often misunderstood and undervalued. Behavioral supports may be overlooked as a treatment option for people with mental illness because when we think of "behavior" we associate it with things that we can readily observe such as breaking objects, biting, or refusals to complete personal hygiene whereas mental illness is viewed as an internal or physiological state that we cannot easily observe. It is often misconstrued that there is nothing behavioral supports can do to address behavior that is attributed to an internal state. Griffiths, Gardner, and Nugent offer a comprehensive and individualized approach to functional behavioral assessment that incorporates assessment of both biomedical and socio-environmental influences.[1] Biomedical factors may play a part in explaining the occurrence of problem behavior.

Behavioral assessment can effectively be utilized to understand the interaction between physiological (biomedical) and environmental factors. For example, an individual is diagnosed with an anxiety disorder and when faced with an anxiety-provoking situation that results in physiological changes such as sweating and a pounding heart, a problem behavior such as physical aggression is triggered. An FBA can assist in identifying those situations that are associated with the physiological symptoms of anxiety so that behavioral strategies can be put in place to prevent or reduce the likelihood of physical aggression. Additionally, the role of other

biomedical factors such as medications, sleep, and medical conditions may be discovered during the FBA which aids in the development of comprehensive behavioral interventions.

As the needs within our system grow so does the complexity of behavior. Factors like trauma, neurodevelopmental differences, environment, and genetics all play into how an individual behaves. It can create a confusing picture and many teams are not sure where to begin or what to address first. Utilizing a functional behavioral assessment can help to clarify that picture and to sort out the complexities. Mental health diagnoses are at their essence a collection of visible behaviors and internalized thoughts and emotions.[2] It is not easy for the individual to sort out and verbalize nor is it easy for the outside observer. Practicing the use of purposeful, evidence-based tools allows the individual and the support team to better define and understand what is happening. Furthermore, it can potentially be determined what other factors influence the symptoms and can be changed or adapted to improve the outcome.[3] There is evidence dating back to some of the very first behavior analysts that indicates that the modification of antecedents and triggers can produce different outcomes for those living with mental illness. In fact, behavior modification rooted in functional behavior assessment was used to support things like improvements in social skills, working skills, and overall independent living over 30 years ago.[3]

Misconception #2: Behavioral support is the only treatment modality that will address challenging or problematic behavior.

Effective behavioral supports require a multidisciplinary approach. This is especially true when the person receiving support has complex needs. Complex needs are complex because supports require a biopsychosocial approach – it's never one thing.[3] As mentioned above, behavioral

assessment can effectively be utilized to understand the interaction between physiological (biomedical) and environmental factors. Behaviors have a suspected physiological cause. It is within the scope of behavioral support to collaborate with other professionals to develop a holistic plan that includes recommendations and instructions from a multidisciplinary team, especially when the FBA does not demonstrate a clear relationship between environmental antecedent and behavioral function.

These professionals include:

- **Psychiatrists** for when the individual has a suspected or diagnosed condition that may require medication.
- **Mental Health Professionals** for when there is a suspected or diagnosed mental health condition that is outside the scope of practice for the behavioral specialist.
- **Medical doctors** for when there is a potential physiological cause that has been confirmed or one that has not been ruled out as a cause. A rule of thumb with a quality FBA is to rule out anything that may be medical first before developing behavioral-based strategies. This is especially important when the individual is experiencing pain, sleep issues, or food-related issues.
- **Clinical Specialists** such as substance abuse counselors, or sexuality specialists for when there are needs outside the behavioral specialist's scope of competence.

Some of these professionals may already be involved when this person becomes known to the behavioral specialist and some may be identified during the FBA process when the behavioral specialists identify needs beyond their scope of practice and seek recommendations from relevant professionals. The resulting Behavioral Support Plan (BSP) should be a document that is

consistent with and informed by the treatment plans developed by all members of the multidisciplinary team and is aligned with the individual's values and goals.

Misconception #3: The more complex a person's needs are, the more behavioral support is required.

One of the most common yet unfitting assumptions we encounter in supporting people with complex needs (i.e., needs requiring significant attention, resources, or supports) is that increases in maladaptive behavior should be met with an equivocal increase in service. In other words, the more concerning behavior a person exhibits, the more we attribute a need to increase direct behavioral supports. However, an increase in direct support is not always the answer. Of course, there are times where the challenges a person exhibits can be mitigated by increasing direct service, but often these increases can have an inverse effect, and can even exacerbate the problem. At its core, behavioral support is about the consistent implementation of the BSP by the entire support team.

As a review, let's provide simple explanations for these two approaches.

- **Direct Service:** Direct implementation of strategies discussed in the BSP. These supports are often implemented by the behavior specialist, staff, family, or other caregivers and with the person themselves.
- **Indirect Service**: Analysis of fidelity of others implementing the plan through training, observation, data review, and feedback. Indirect services often occur without the person present, but always has the person as the focus.

In order to fully understand how to effectively support behaviors, we should first consider the

philosophy of "quality over quantity." Sometimes it is not necessarily how much direct support is provided, but rather the content, quality, and implementation of these services that truly drive effectiveness. Yet, the first response by many teams often involves some form of direct service increase. Instead of providing a quantitative response characterized by increases in direct support, emphasis should first consider a review of qualitative factors often found through indirect means. The focus should incorporate a review of plan fidelity and consistency of plan implementation. Additional indirect activities should incorporate a review of data, elicited feedback from the multidisciplinary team, observation, and additional training to supporters. It's through these activities where most factors limiting success can be identified, resulting in a more profound impact than simply increasing direct support.

In summary, if response efforts maintain focus on indirect strategies that seek to analyze data and evaluate fidelity, changes can be made to better modify the environment and best meet the person's individualized needs. When we question the effectiveness of supports, our focus is not always best served by increasing direct service with the individual. Instead, this provides an opportunity to enhance the implementation of indirect strategies that enable us to better understand the problem and how to best support the person. This includes an emphasis on:

- **Plan Fidelity:** Is the plan being implemented appropriately and consistently?
- **Training:** Do supporters require additional training to implement the plan more effectively and consistently?
- **Data Analysis:** What does the data tell us about the current situation?
- **Plan Modification:** Does the data and additional analysis suggest a need to make changes to the current plan?

Adopting this approach empowers the multidisciplinary team to work collectively and ensure the application of supports is provided in a consistent manner, as they were intended, and helps to alter the practice of simply adding already ineffective direct supports as a means of better managing the person's needs. Without these considerations, there is an increased risk of over-reliance on the behavioral specialist. After all, effective behavioral support is evidenced by empowering other members of the team to understand the function of challenging behaviors and implement individualized strategies with integrity.

Misconception #4: Behavioral support is primarily focusing on developing rewards as reinforcement for the person to decrease their challenging or problematic behavior.

When people think about behavioral support, many envision Pavlov's dogs or Skinner's reinforcement theory. Many think of sticker charts and token economies or tangible rewards used in discrete trials when training new skills. Though these are all components of its history, the field has grown from this simple notion of rewards and consequences to a rich tapestry of understanding and perspective rooted in the experience of the person supported.

A behavioral approach, at its core, is all about reinforcement, but the principles of reinforcement are often misunderstood. All humans engage in behavior that is functional to them. This means that our individual behavioral repertoires are developed throughout our lifetimes based on our experiences and responses to those experiences. We continue to engage in behaviors that have been successful in meeting our needs in different situations throughout our lives. Favorable consequences or outcomes make it more likely that the behavior that led to that outcome will occur in that situation in the future. This is the core of reinforcement theory, but behavioral support is so much more than a focus on decreasing challenging behavior by pairing new

behaviors with rewards or privileges thought to be reinforcing.

Through the FBA process, a behavioral specialist should have a functional understanding of a person's challenging behavior. This includes an understanding of the situations in which challenging behaviors have historically occurred as well as an understanding of WHY those situations may be challenging to the person. To understand the function is to understand the reinforcement history of that behavior. In practice, this means if the behavioral specialist has completed a quality FBA, they already know the needs of the person in specific challenging situations as well as what will likely reinforce more efficient alternative and replacement behaviors. Positive behavioral supports focus on modifying or avoiding those situations to help the person be more successful in the future. As one cannot simply suggest an environment change in isolation, one must couple that with skill-building, "...to promote performance of desired behaviors, support planners must ensure that these behaviors have been taught and that they produce adequate maintaining consequences (reinforcers) when they occur.[4]" This is accomplished in two ways. First teaching more efficiently achieves the same function when preventative strategies are not effective, and second, by teaching alternative behaviors that help the person cope with some of the challenges presented in those situations.

Behavior support in current practice takes a holistic approach to assessment and implementation. When a problem behavior has been identified and supports are sought, the gathering of information begins. As the assessment gives shape to the behavior support plan, we see the proactive nature of behavior support emerge. It is not about responding to a crisis and stopping the behavior at that moment but rather setting up the internal and external environment to respond proactively to avoid the crisis altogether. The plan focuses on identifying alternative, adaptive responses to a given trigger or antecedent and practicing those to create a fluidity that

feels natural and then becomes the default.

Interventions focus on modeling, coaching, teaching, and transferring skills to the team and individual supported. This can only be accomplished through ongoing assessment and feedback of the efficacy of interventions and their outcomes. It is not aversive conditioning but rather reteaching the response to triggers and antecedents and building the necessary skills to do so. Carr's discussion suggests one can be confident that positive behavior support as an approach focuses on skill-building and environmental design as the two vehicles for producing desirable change.[5]

If a person is only working for a reward when that reward is removed, the desired behavior will not likely continue. However, if you teach a person how to respond differently or adapt an environment to be more suitable, systematically fading and modifying the reward contingencies as part of the larger plan, the conditions themselves work to change the behavior and lead to long-lasting success.

Misconception #5: There is one right way to conduct an FBA.

Behavioral support is rooted in FBA and therefore functional understanding of behavior. The FBA is not a one-time thing, but an ongoing process that should be the core of any BSP. Behavioral specialists should always base their interventions on the most current and comprehensive functional hypothesis of challenging behavior.

Unlike other assessments and tools, the FBA is an individualized process to understand why someone does what they do. By collecting information, analyzing information, and making data-based recommendations, a comprehensive BSP can be developed. If all FBAs are identical, you may be missing key information needed to understand the person you are supporting.

Recognizing that an FBA is an ongoing process ensures that teams have the most up-to-date information and data to understand the function of the targeted behaviors. That being said, there are best practices to the FBA process that should be considered to ensure the BSP approaches treatment and intervention comprehensively, holistically, and individualized to the person.

The first best practice of the FBA process is through indirect and direct information gathering. Record reviews are one method of indirect information gathering which offers a historical perspective of the individual and the targeted behavior, while also gathering social, medical, educational, and/or behavioral information. There are no rules around what information must be gathered during record reviews, however, the information gathered should be relevant to the targeted behavior and understanding what may be maintaining the behaviors. Interviews are another form of indirect information gathering that offers personal perspectives from the individual and people who know them well. These personal perspectives can be gathered through questionnaires, rating tools, and/or structured/unstructured conversations. Some examples of these tools are the functional Assessment Interviews (FAI), Motivation Assessment Scale (MAS), Questions About Behavioral Function (QABF), and Functional Assessment Screening Tool (FAST). The questionnaires, tools or assessments that are used during the FBA process should provide enough information to formulate a hypothesis that will drive the multi-component behavioral support plan.

Direct information gathering includes observation of the individual in their natural environment. It should include data collection of the targeted behavior to more clearly define the behavior, support or refute the interview information, determine baseline levels and current levels of skills, provide objective information on conditions surrounding behaviors, and lead to a more accurate hypothesis of the behavior. The data collection method and items collected need to be specific to

the individual. It should be succinct, targeted to the behavior of the individual, and written using clear, quantitative, consistent, and targeted language. Be sure to consider other elements of data collection beyond a frequency count (e.g. duration, latency, intensity).

Once the data is collected, a thorough analysis of the information to identify patterns, form hypothesis statements, and inform the data-based recommendations should be completed. Often, Excel or other similar programs are used to create graphs, but there is great flexibility in how the information should be analyzed and presented to the person and other team members. The data-based recommendations should then be identified based upon the information gathered and analyzed as part of the FBA process.

Many think this is the end of the FBA process, but this process should be ongoing for the duration of the time the person receives behavioral support. As support is provided and ongoing data is collected and analyzed, the behavioral hypothesis may change and the strategies within the BSP must also change to reflect the most current hypothesis. The FBA must also be updated to reflect these changes.

Misconception #6: Behavioral support and therapy are the same.

The education and experience of a therapist or counselor provide an important perspective to behavioral support, but in practice it is very different from traditional therapy, counseling, or social work. Behavioral support is about more than the behavioral specialist's "sessions" with the individual. It is more than providing access to resources and tools. Behavioral support is more about DOING than THINKING. It uses data to assess problematic behaviors and creates a team implemented plan to teach skills, express needs, and create more successful environments for the individual. Successful behavioral support relies primarily on the time outside the direct

interaction with the behavioral specialist. Therapy, on the contrary, helps someone develop strategies to change the way someone thinks. Primarily, a therapist works directly with the person to process feelings and emotions without direct intent to manipulate or change the environment and others in their environment.

Sometimes we feel like people need access to certain supports and when there are seemingly barriers to accessing needed supports, like counseling or therapy, the behavior specialist jumps in and takes on a role outside their scope. This well-intentioned act can be detrimental to the individual receiving services and can cross an ethical line that should not be crossed. Programs have different service lines for a reason. If someone needs therapy, they should receive therapy (in addition to behavioral support).

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Biographies

Amy Alford M.Ed., BCBA, is a Senior Clinical Consultant for the Bureau of Supports for Autism and Special Populations (BSASP), Office of Developmental Programs (ODP). She has been supporting children, adolescents, and adults with autism and other developmental disabilities for over 15 years in community, home, and school settings. She holds a master's degree in Special Education and in 2011, became a Board-Certified Behavior Analyst (BCBA). Prior to joining the BSASP clinical team in 2008, Amy was a behavioral specialist for a provider in the Behavioral Health Rehabilitation Services (BHRS) system (now Intensive Behavioral Health Services (IBHS)). She spends much of her time leading training efforts across ODP and continues to apply principles of positive behavioral supports and applied behavioral analysis throughout her work.

Heidi Arva has worked as a Clinical Consultant for ODP's- Bureau of Supports for Autism and Special Populations since the Spring of 2016. Prior to working at ODP, she spent over 15 years providing direct support to adults, children, and families within the mental health system.

George Bell IV, MA is is currently assigned as the Regional Clinical Director for the Northeast Region's Office of Developmental Programs, Bureau of Community Services. He has worked with the state office for seven years. Prior to his current position, he worked with a private provider agency for more than twenty years supporting individuals with intellectual and developmental disabilities in community-based programs.

Emily Burger MS, NCC is a Special Populations Professional in the Bureau of Supports for Autism and Special Populations. Prior to joining ODP, Emily worked with both the mental health and intellectual disability/autism community. She provided a wide variety of supports

spanning from children's services, psychiatric rehabilitation, and residential community homes to most recently directing a behavioral support program. Currently she works with the Special Populations Unit focusing on complex cases with children, infant mental health and communication.

Heather Easley has worked for the Office of Developmental Programs (ODP)- Bureau of Supports for Autism and Special Populations as a Clinical consultant for 4 years. Prior to her work at ODP, Heather spent over 10 years supporting children, and adults across multiple systems.

Lindsay Gaworski joined ODP as a contractor in 2021 as a Clinical Director within the Western Region. Lindsay holds a Master of Education in Special Education from the University of Pittsburgh, with focused and intensive coursework in Applied Behavior Analysis. In addition, Lindsay has over 12 years of professional experience across multiple systems service lines including serving 2-5 year old children with ASD within a partial hospital setting, Intensive Behavioral Health Services (formerly BHRS) working with youth and families as a BSC while serving as a provider Autism Director, and most recently a Clinical leadership role within a residential provider. Lindsay is a graduate of the Capacity Building Institute, Year 3.

Jordan Hollander M.Ed., BCBA is a Senior Clinical Consultant for the Office of Developmental Programs – Bureau of Supports for Autism and Special Populations. He has been working for the past 12 years to help people on the autism spectrum identify goals, and work towards achieving them through a person-centered approach that utilizes the principles of positive behavioral supports. Jordan has worked in various Direct Support Professional roles as well as in clinical and operational management positions for various service providers

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Pamela Treadway, M.Ed., is a Senior Clinical Consultant for the Bureau of Supports for Autism Services and Special Populations, Office of Developmental Programs, Department of Human Services. She has been supporting individuals with disabilities for 42 years in home and community settings. She received a master's degree in special education from Lehigh University and has worked with adults and children with autism, intellectual disability, and emotional and behavioral disabilities.

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Employing the Principles of Positive Behavior Support to Enhance Family Education and Intervention

Meme Hieneman & Sarah Fefer

Introduction

I am honored to share this article to memorialize my inspiring friend, mentor, and colleague: Dr. Meme Hieneman. Meme lost her long and courageous battle with cancer in August 2021. This is just one snapshot into Meme's wide-ranging contributions to the field of Positive Behavior Support (PBS), including research and writing, teaching, mentoring, consulting, and advocacy work focused on using this behavioral approach to enhance the family quality of life. Her legacy includes many articles for *Parenting Special Needs* magazine, creation of the Home and Community Positive Behavior Support Network, development of the *Practiced Routines* curriculum, authoring two PBS guides for families, leading numerous innovative and influential research projects, and much more. I encourage you to continue to read and be inspired by her work focused on applications of PBS in-home and community contexts.

In 2015, Meme and I co-presented at the annual conference of the Association of Positive Behavior Support to share our summary of the literature related to PBS in the context of family life. We shared models of effective family-focused intervention strategies from across disciplines and highlighted the PBS principles present in several existing evidence-based interventions for families. Our goal was to show how PBS was present in approaches that work to improve family lives. Sharing this work with fellow PBS professionals energized us to write this article to introduce the core principles of PBS to a broader range of researchers and practitioners focused on supporting individuals and families. We drew on examples of well-known family

interventions to highlight their foundations in PBS principles and called for additional focus on the entire family context (rather than just on an individual or their caregivers) in future research and practice. I hope that this summary of core features of PBS will inspire others to think about how these features may be present, or how they can be enhanced, across a variety of prevention and intervention service delivery approaches in partnership with families.

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Abstract

Positive behavior support (PBS) is an evidence-based approach for supporting adaptive behavior and addressing behavioral challenges. It is critical that families have access to effective evidence-based behavior support practices for both intervention and prevention because they lead to better outcomes for families, and counter-productive family management practices have been shown to further escalate children's behavioral challenges. PBS has been demonstrated to be effective with individual children with serious behavior challenges in family homes and features of PBS are evident in common family-based intervention approaches. Unfortunately, complete application of PBS in family contexts has not been fully explored or conceptualized. The purpose of this paper is to define the core features of PBS including lifestyle enhancement, assessment-based intervention, and comprehensive support plans (i.e., including strategies for prevention, teaching, and management). Examples of how the features of PBS are currently being employed within the field of PBS and within other evidence-based parent education and support programs are provided. Suggestions for how collaboration, assessment, data-based decision making, comprehensive intervention, and tiered approaches to service delivery may be used to enhance behavioral support for families are offered. Lastly, future directions for research and practice are recommended.

Introduction

Positive behavior support (PBS) is an evidence-based approach for supporting adaptive behavior and addressing behavioral challenges. It combines the principles of applied behavior analysis with approaches from other disciplines (e.g., ecological and community psychology, biomedical science, education) to improve the utility of behavioral intervention within typical home, school, and community environments.[1,2,3,4] Although PBS was originally developed to overcome behavioral challenges of individuals with significant disabilities[1], the approach has now been used successfully with a wider range of populations and applied within larger service systems (e.g., schools, mental health systems, early intervention programs, community agencies) to promote generalized behavioral improvements.[5] Complete applications in family contexts, however, have been limited – even though the potential benefits are clear.

Families often experience significant stress related to child rearing, especially in dealing with children's behavioral challenges.[6,7,8] It is estimated that about 5% of children and youth experience challenging behavior[9], with that figure increasing to 15% for children with disabilities.[10,11] Siblings often display similar behavioral challenges[12], making this a family problem. Significant behavior problems may delay children's development, interfere with family routines, alienate children and families, and damage relationships.

When parents are knowledgeable and skilled in effective behavioral support practices, they may use these practices proactively, promoting family stability and creating environments in which children thrive.[13] When parents face behavioral challenges with their children – an experience integral to family life - and do not possess the necessary skills and knowledge to intervene effectively, they may be inclined to resort to inconsistent, overly passive, or hostile approaches

to managing child behavior.[14] Counter-productive family management practices have been demonstrated to further escalate children's behavioral challenges.[15,16] Therefore, it is critical that parents have access to effective evidence-based behavior support practices for both intervention and prevention.

PBS has been demonstrated to be effective with individual children with serious behavior challenges in family homes[17]and aspects of PBS are clearly evident in a variety of parent education programs.[13, 18] It does not appear, however, that PBS has been comprehensively applied or assessed within family-based programs. In reviewing the literature, it is evident that some, but not all, features of PBS are incorporated in interventions focused on the child within the family or on the family system as a whole. In this article, we will define the core features of PBS, provide examples of how PBS is currently being employed within evidence-based parent education and support programs, and offer suggestions for how PBS may be used to enhance behavioral supports for families.

Features of Positive Behavior Support

PBS combines the technical foundations of applied behavior analysis with features derived from other fields to improve its practical utility within typical environments and routines. PBS is defined based on three core features: lifestyle enhancement, assessment-based intervention, and comprehensive support plans.[1,19] Each of these features are described below with supporting literature.

Lifestyle enhancement

A foundational feature of applied behavior analysis is that the goals, interventions, and outcomes must be important and acceptable to the target individual or have "social validity".[20,21] In PBS, social validity has been interpreted as the extent to which interventions address and enhance quality of life, support teams are engaged in the process, and improvements are seen not only for individuals, but also throughout the systems that support them.

Quality of life

Quality of life refers to the extent to which an individual is satisfied and comfortable in their living circumstances.[22] Quality of life is a complex multi-faceted concept that includes health and safety, self-advocacy, interpersonal relationships, productive activity, and community engagement. A critical element of life quality is self-determination – the degree to which people who are the focus of intervention efforts have a "voice and choice" in the process.[23] The ultimate outcomes of PBS efforts are not only to develop skills and remediate behavior challenges, but to produce substantive improvements in lives of individuals, families, and other support and service providers.

Engagement of support teams

To ensure that PBS efforts are appropriate to the circumstances and ultimately successful, it is necessary to actively engage individuals and those who support them.[24] Support teams commonly include family members, friends, neighbors, teachers, employers, therapists, social workers, and a host of other administrative and direct service professionals who may be influential in the success of PBS. The core members of these teams are included in goal

identification, assessment, plan design, implementation, and evaluation.[25]

Support teams are engaged through planning processes that clarify desired outcomes and encompass action planning to work toward those outcomes. Various person-centered planning methods have been used within PBS.[26] These planning processes guide support teams to establish a positive, unfettered vision for their future, assess available resources and potential barriers, and create a stepwise plan to work toward the goals. The limited research on the effectiveness of person-centered planning appears promising[27] and its pragmatic value in PBS is evident.

Multi-tiered approach

PBS not only focuses on individuals, but also extends to the groups and systems that support them. PBS has been used extensively within schools, resulting in improvements in student attendance, academic performance, and behavior.[28, 29] In addition, PBS is beginning to be employed within mental health and family support programs.[30,31]. These system-wide applications apply PBS principles within a multi-tiered framework in which effective behavior support practices are provided for everyone within the system proactively and universally, as well as more intensively and systematically for individuals who are at risk or experiencing significant behavioral challenges.

Assessment based intervention

Using objective data to inform and evaluate intervention is a cornerstone of PBS. It includes conducting assessments to inform strategy selection and tracking of both the integrity of implementation and outcomes of the intervention.

Assessing Contexts and Functions

PBS is grounded on the premise that effective behavioral support must be individualized based on the 1) needs of the focus individuals, 2) immediate and broader circumstances in which the individual function, and 3) consequences maintaining adaptive and maladaptive behavior patterns.[32,33] It is therefore important to collect data to determine the purposes or functions behaviors are serving. Functions may include seeking attention from other people; acquiring tangible items such as food, money, games, or other desired objects; avoiding, delaying, or escaping unpleasant situations; or obtaining sensory outcomes such as increased stimulation or physical release. It is equally, if not more important, to identify the specific circumstances that set the stage for these functions.[34] For example, individuals will most likely seek attention or items when deprived of them and will only endeavor to escape from situations that are uncomfortable or difficult.

Functional (and ecological) assessments in PBS involve systematically gathering information associated with the possible contexts and functions of behavior through interviews, record reviews, and observations.[35,36] A variety of interview tools may be used from simple rating scales[37,38,39] to more elaborate questionnaires.[36] Direct observations are typically structured to obtain information on the antecedents, behaviors, and consequences[40] or patterns of behavior across activities and time frames.[41]

Functional Behavior Assessments (FBAs) draw from multiple sources (e.g., interviewing multiple people, observing across settings and situations). Once sufficient data are collected, patterns of behavior are summarized in hypothesis statements. These statements describe the behaviors of concern, the circumstances in which they are most and least likely to occur, and the

consequences that reliably follow the behavior (namely, their functions). For example, a hypothesis might be: "When Louis is asked to complete a difficult chore and not provided with frequent supervision, he will 'get into stuff' (e.g., take apart items or construct games). This delays completing the task and results in his parents increasing their guidance and attention." These statements reflect the 'best guess' of the patterns but must be supported by data to be validated. That is done by either testing the hypotheses by manipulating events surrounding the behavior or implementing interventions based on them and evaluating their outcomes.[42,43]

Data-based decision making

Objective data are used to assess both the fidelity with which strategies are employed and the outcomes of intervention. These data guide decision-making and determine the need for adjustments to strategies and supports.[44,45] For plans to be effective, they must be implemented as designed and with consistency. Therefore, a key feature of PBS intervention is to establish systems (e.g., checklists, periodic observations of strategy use) to ensure fidelity in practice.[46] The data on behavior patterns may also offer insight into whether strategies are used successfully since variations in frequency/intensity can indicate that plans are not being used as intended under every circumstance.

Data are collected on behaviors that are most important and/or the best indicators of progress. These data may include discrete measures (e.g., frequency, duration) of particular behaviors that are a focus of intervention. The behaviors measured may include those targeted for increase such as appropriate communication (e.g., using words rather than physical aggression), independent participation in daily activities (e.g., household chores, work or school, self-care), or use of particular coping strategies. They may also include behaviors individuals need to decrease to be

successful or safe including, for example, yelling at or threatening other people, stealing, or engaging in behavior that disrupts valued routines.

In addition to these more narrowly defined behaviors, PBS also assesses quality of life outcomes as described above).[5] As a result of intervention, data should capture whether people are able to go more places, do more things, and gain more enjoyment and satisfaction from their daily lives.[47]

Since PBS is implemented in complex community settings (vs. segregated or controlled environments) and within natural routines, measures often need to be adapted to improve their ease of use for individuals and their caregivers. PBS practitioners therefore often supplement or replace the direct observation or continuous recording procedures commonly used in ABA with rating scales and sampling practices.[44] By doing so, the rigor may be reduced, but contextual fit and fidelity of implementation are typically increased.

Comprehensive Intervention

Interventions in PBS are directly linked to the patterns identified in the assessment. They include immediate antecedent and consequence interventions, as well as broad lifestyle changes to support the more discrete strategies. A useful framework for selecting appropriate strategies is the competing behavior model.[36]Using this model, we identify interventions that are logically associated with particular patterns.

Components of PBS

PBS interventions are not stand-alone procedures, but include a combination of proactive, teaching, and management elements. These elements are described briefly in the following

sections.

Proactive strategies include environmental and social arrangements that prompt positive behavior and make engagement in problem behavior unnecessary by modifying or removing the triggering stimuli.[49] Examples of proactive strategies include: noncontingent access to attention, tangibles, and other reinforcers[50]; offering choices between items or activities[51]; activity scheduling to prepare for upcoming events[52]; and curricular modifications such as embedding easy or interesting features or reducing length or difficulty of tasks.[53, 54]

Teaching skills includes direct instruction in two types of competencies: (a) replacement behaviors and (b) other desired skills. Replacement behaviors are more appropriate responses that meet the same function as behaviors of concern. Functional communication training, for example, is a well-documented approach in which individuals are instructed to use words or other methods of expression to ask for items, attention, or breaks, depending on the purpose or function of the behavior.[55, 56] More complex skills such as negotiation and problem-solving may also be taught as replacement behaviors. Other desired skills allow individuals to participate successfully in typical daily routines and meet the expectations of their circumstances. These may include social (e.g., engaging in conversations, playing games) and daily living (e.g., completing chores, homework, or other tasks) skills.[57]

Managing consequences involves maximizing reinforcement for positive behavior and reducing or eliminating reinforcement for problem behavior.[58, 59, 60] To manage consequences effectively, the function of the behavior – access to attention or items/activities, escape, or sensory outcomes - must be clear and access to the specific reinforcers controlled. For example, consequences may involve delivering high rates of attention or reducing demands when individuals are cooperative,

but not when they are complaining or aggressive.

Implementing PBS plans

Proactive, teaching, and management strategies are combined into comprehensive PBS plans that are tailored to the circumstances. These plans should be in writing and include goals and behaviors of concern, a summary of the patterns affecting behavior, descriptions of strategies and how they will be employed across situations, and methods for monitoring outcomes. For example, if a person's behavior is motivated by attention from peers and the goal is to improve relationships, the plan might include creating opportunities for appropriate interactions (e.g., scheduling supervised gatherings, joining clubs, setting aside time for 1:1 interaction), teaching the individual any communication or social skills needed to obtain attention, and encouraging peers to respond to conversational turn taking instead of name-calling or threats. The individual could track the frequency of his or her interactions with other people and, together with peers, rate their quality.

In addition to these immediate strategies, other supports focused on setting events are often included as well. This means not only focusing on remediating behavioral challenges, but on creating universal, proactive measures to support positive behavior. Examples of these type of supports include restructuring routines or settings to better match people's needs, rebuilding damaged relationships to improve the overall quality of interactions, addressing health or safety concerns that may be affecting behavior, or simply finding ways to offer more choice and personal autonomy.

As the PBS plan is being finalized, it is critical to consider its contextual fit given the people, settings, and systems that will be influenced by the plan.[61] Questions to guide this consideration include: Is the plan right for the individual(s) for whom it is designed (i.e., given their characteristics, needs, abilities, preferences, and motivations)? Is the plan feasible given the resources available and doable within typical routines and settings? Do caregivers and others involved in supporting the plan have buy-in and the capacity to implement? Are broader systems (e.g., home, school, work, community) aligned with the plan and therefore likely to enhance sustainability[62]? Responses to these questions determine whether a plan needs to be adapted or whether accommodations may be needed.

Developing an action plan that addresses the considerations above and spells out how each aspect of the plan will be put in place is important to support implementation.[44] The action plan includes what exactly needs to be done, who will do it, and when it will be completed. Action items typically include rearranging environments, establishing routines, obtaining resources, providing training and coaching, and establishing systems for monitoring implementation and outcomes and communicating about progress. In addition, action planning often includes ways to support and motivate plan implementers (e.g., via reminders, tools, incentives).

A key to ensuring that PBS plans will be implemented consistently and effectively is to embed strategies within typical daily routines.[63] Doing so reduces the demands on implementers and increases sustainability as the strategies become part and parcel of routines themselves. Examples of target routines may include tasks (e.g., chores, homework, work responsibilities), personal care, play or leisure activities, errands, and community outings. Effective instructional practices that are inherent in the features of PBS may be used without disruption. These include defining specific skills to teach; arranging settings to promote independence and success;

modeling, prompting, and shaping behavior; and using differential reinforcement to establish and maintain skills over time.

EXAMPLES OF APPLICATION OF PBS FEATURES IN FAMILY INTERVENTION

Many well-established family education and support programs include features that are consistent with those that characterize PBS. In this section, we will highlight some examples, and demonstrate that, although comprehensive family-based PBS is not commonplace, current approaches do embrace these principles. The goal is not to provide an exhaustive review of all possible programs, but to share illustrations from the field of PBS and broader family intervention approaches.

Lifestyle Enhancement

Quality of life

Both researchers and practitioners have emphasized the importance of focusing on lifestyle enhancement when supporting behavior in family contexts. While few examples of direct quality of life measurement at the family level are available, Smith-Bird and Turnbull[64] demonstrate that the intervention approaches and outcomes reported in past research on family focused PBS align with the key domains of the *Beach Center Family Quality of Life Scale.* Three themes related to quality of life were found in their analysis of past family PBS research: a focus on daily routines that are valued by families, improved family interaction, and increased safety/physical well-being for all family members.

Examples of routines that have been addressed in family-based PBS research include dinner, play, cleanup, bedtime, bathroom, or grocery shopping, or eating at a fast-food restaurant[65, 66,67]

also demonstrate ongoing direct measurement of individual quality of life through a community activity inventory. More comprehensive application and measurement of quality of life within family contexts in PBS is surprisingly limited.

Beyond literature in PBS, several evidence-based programs focus on empowering families to determine desired outcomes that will benefit their overall lifestyle. For example, the continuum of interventions offered within the *Positive Parenting Program*[68] provides choices for families and promotes self-determination, while the *Family Check-Up* (FCU) program capitalizes on parent motivation by providing a menu of intervention options to families after an initial assessment and feedback session.[69] Meta-analytic research suggests that involving parents in generating solutions is associated with higher ratings of satisfaction, self-efficacy, and social support.[70]

Comprehensive family intervention programs also directly measure outcomes associated with family quality of life. The *Multidimensional Foster Care* program[71] measures quality of life through parent report, and targets other child and parent resiliency outcomes including interpersonal relationships, stability in home context, and social support.[72] *PPP* has been shown to enhance parent and child well-being and parent relationship quality[73], and *FCU* led to increased parental perceptions of social support and relationship satisfaction, decreased parenting stress, and fewer child challenging behaviors.[74] The *Incredible Years* programs, which target increasing the family support network, have been shown to increase positive family communication and parental self-confidence, and reduce parental depression.[18]

Engagement of support teams

Given the focus on enhancing quality of life, it naturally follows that programs supporting

families would endeavor to engage people across different systems and settings. This objective is explicit in wraparound[76, 77] and group action planning[77], both of which have been combined with PBS. The wraparound process, like PBS, involves a team of individuals working together to develop supports to enhance the life of individuals with disabilities across multiple important life domains.[79] Group action planning expands on person-centered planning practices commonly used in PBS and is also directed by the preferences of an individual and their family.[77] These approaches focus on coordinating supports by engaging all relevant family members and service providers in assessment, planning, and implementation to remediate challenges.

Coordinating multiple service providers is also common within other family-centered intervention programs beyond PBS, such as *MTFC*, in which weekly meetings are held with the family, clinicians, therapists, and skills coaches to review progress and engage in treatment planning.[80] The *FCU* program also includes an "ecological management" option on the intervention menu for families who would benefit from coordination of the intervention with other child and family-focused community services.[69] Family and support team involvement in intervention planning, and the measurement of outcomes associated with positive child and parent lifestyle change, are primary themes across a broad range of evidence-based family focused interventions.

Multi-tiered approach

Multi-tiered service delivery can be used within systems that provide support to multiple families to ensure that the level of service provided is aligned with the need demonstrated by the family. Several research teams have proposed the application of a multitier framework to enhance the efficiency of family-engagement practices in early childhood settings[31], family support in urban

family service agencies[31], and parent training for young children with developmental disabilities.[81] Tier 1 includes low intensity strategies available for all families such as reading materials about positive parenting strategies[81, 82], parent workshops, or parent-teacher conferences Tier 2 involves more intensive group-based parent training or facilitated problem-solving sessions.[31,80, 82,] Tier 3 includes individualized supports for families with more persistent and intensive needs such as home-based sessions with video feedback[80], structured reading or home-visit programs[80], or direct training.[31] The model empirically evaluated by Phaneuf and McIntyre[82], but not frequently utilized in practice, is based on response to intervention logic, with all families starting with tier 1 supports.

PPP is a well-researched example of a multi-tiered model of family support.[83] Triple P or *PPP* includes five levels or tiers starting with universal communication strategies such as posters or billboards, tv or radio commercials, or brochures. The aim of this level of support is to reach all families to share parenting strategies and de-stigmatize asking for help.[84] The second level of support involves brief parent support during a routine pediatrician visits, followed by level 3 which includes repeat brief and specific consultation about child behavior. Level 4 is intensive group-based training in positive parenting skills, and level 5 is an individualized *Enhanced Triple P* program.[84] This model of parent training is unique in that it acknowledges the unique needs of families, embeds family support within the broader societal context by implementing universal campaigns to put parenting on the public agenda, and draws upon existing services within the community.[84] These aspects likely contribute to *PPP* being one of the most widely adopted models of parent training internationally.

The *Incredible Years* programs also use multi-tier logic in acknowledging that children present with various needs which may be targeted through varying levels of direct intervention with

children, teachers, or parents, or through more comprehensive combined approaches.[84] Within this conceptualization of the tiered model less intensive supports are viewed as those that focus on the child or parent alone, rather than intervening at the level of the family system by working with both children and parents to reduce challenging behavior. Webster-Stratton and Hammond[85] demonstrated that working with both children and parents (versus child *or* parent-focused intervention) produced more positive and sustainable outcomes; however, the authors acknowledged that this comprehensive approach may not be needed by all families. The effectiveness of this more intensive combined approach has also been demonstrated by *Parent-Child Interaction Therapy*.[87]

Assessment-Based Intervention

Assessment of contexts and functions

Collaboration between providers and families to complete functional assessments (e.g., interviews, observations, rating scales) and inform routine-based functional interventions is common within family-based PBS.[88] Several research teams emphasize partnering with family members during this assessment process or supporting family members to carry out comprehensive functional assessment processes within family homes and during natural routines.[89, 90, 91] This process often involves families identifying the most problematic routines for their child to serve as the context for the implementation of PBS, as well as the identification of prioritized target behaviors.[65, 66, 92, 93, ,] Moes and Frea[63] demonstrate that directly interviewing parents to gather information about the family context (e.g., routines, goals, supports, demands) can enhance the effectiveness of family-centered interventions such as *Functional Communication Training*.

Preliminary work by Lucyshyn and colleagues[94] also suggests that clinicians should directly assess parent-child interactions to determine patterns of reinforcement between parent and child that may escalate problem behavior. A possible reciprocal interaction between parent and child behavior is depicted in an illustration of the coercive family process in Figure 1[95] in which child behavior prompts unproductive parental responses, which thereby escalate child behavior. Using this perspective, the child's behavior within the family context is of interest, along with the parent and child reactions that perpetuate those patterns and reinforce continuation of parental behavior.

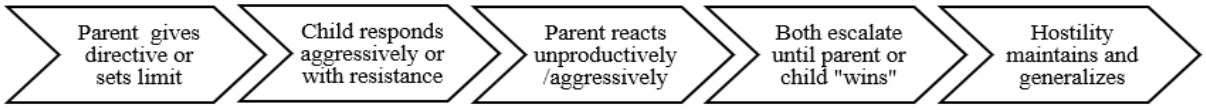

Figure 1. Coercive family process illustration. This figure depicts a common pattern of parent-child interaction that leads to escalating behavior.

This reciprocal or transactional relationship between parent and child behavior is the premise of many family-focused intervention programs that teach parents how to change their responses to their child's behavior to prevent further escalation. *PCIT*[96] involves direct observation of parents and children together, which informs the use of in-the-moment coaching for parents to improve their interactions and reduce coercive processes.[97] The *FCU* program also includes observations of parents and children interacting in the home setting as part of a comprehensive assessment, which is used to inform a parent feedback session using motivational interviewing techniques to support parents in their choice of interventions from a menu of treatment options.[69]

Data-based decision making

The examples of family-based PBS research highlighted in the previous section incorporate multiple systems of data collection including structured observations and standard recording forms to look at the frequency, duration, and intensity of positive and challenging behaviors.[66] These often include intensive direct observation and/or videotaping by the researchers themselves.

Although it would seem essential to engage families in monitoring progress (e.g., in order to capture data across situations throughout the day), there are fewer examples of direct parent involvement in this type of data collection for ongoing decision making.[88,98,] Few studies of family-focused PBS report treatment fidelity data, and those that do tend to use videotaped sessions to complete fidelity checklists rather than involving parents in monitoring their strategy use[92], probably due to limitations in translating this type of intensive data collection from research to practice in family contexts. Lucyshyn and colleagues[66], however, provide a comprehensive example of ongoing data-based decision making in partnership with families by including parent reports of problem behaviors as one source of information to monitor progress and make decisions to alter the intervention.

Family intervention programs beyond PBS provide other examples of data-based decision making within the family context. *PPP* programs include tracking of the fidelity of training components[83] and methods to engage parents in ongoing data-based decision making by teaching independent problem-solving skills and providing tools and strategies to self-monitor the use of specific skills taught.[13] The most intensive individualized version of *PPP*, known as *Enhanced Triple P*, uses assessment data to guide individualization of specific parent training modules

based on family needs.[83] *PCIT*[87]and *Parent Management Training*[99] both use direct and indirect reports of interactions between children and parents to guide the specific components of treatment and to evaluate progress. *PCIT* uses data to inform the length of the intervention; the intervention ends when parents master targeted parenting skills and report that they are confident in managing child behavior.[87]

Comprehensive Interventions

In PBS, interventions are based on assessments and there is some degree of consistency in applying the framework that includes proactive and preventive strategies to address setting events and antecedents that precede behavioral patterns; teaching of desired and replacement skills; and reinforcement for positive, not problem, behavior in family contexts. Duda and colleagues[65], for example, demonstrate that a combination of prevention, instruction, and reinforcement strategies reduced challenging behaviors across multiple home routines (e.g., play, cleanup, dinner). The strategies include social stories, providing choices, increasing proximity to the parent, pre-teaching rules, modeling and prompting appropriate play behaviors, teaching self-monitoring, a reward choice menu, and parent attention and praise. Lucyshyn et al.[66] use similar prevent-teach-manage strategies, as well as information about family ecology to improve the contextual fit of the behavior support plan. Contextualized programs using family information (such as caregiving demands, family support needs, and social interactions goals) within comprehensive intervention programs are shown to be more effective at increasing replacement behaviors and decreasing challenging behaviors[100] and lead to greater sustainability of communication skills.[63]

Pivotal Response Training[101] also incorporates the three elements of comprehensive behavioral

support, with an emphasis on teaching parents to use specific prevention (e.g., increasing child motivation through choice), teaching (e.g., modeling of new skills to encourage communication), and reinforcement (e.g., responding to all approximations of behavior with natural reinforcers) strategies within everyday activities and on an ongoing basis to increase skill development. These components are the basis for other intervention programs such as *Prevent-Teach-Reinforce.*[102] Recent studies show that comprehensive intervention plans developed using the *PTR* model are effective to decrease challenging behavior and increase alternative behavior in young children and demonstrate that parents can effectively implement and generalize this intervention approach within family routines.[103, 104] These PBS components have been integrated into other research as well. For example, Durand and colleagues[17]demonstrate the effectiveness of combining these core components of PBS with a cognitive behavioral therapy intervention to promote parental optimism.

Kazdin's[99] *Parent Management Training* is a forerunner in translating behavioral principles into a comprehensive intervention approach for families. Parents are taught specific behavioral strategies relevant to teaching and behavior management such as praise, planned ignoring, time-out, and shaping within the home context. *Incredible Years, PCIT, Triple P,* and *Multisystem Treatment Foster Care* follow suit and incorporate features of comprehensive behavior support, as well as focus on preventing the coercive cycle. This is accomplished in these programs by teaching parents' prevention strategies (e.g., increased praise and decreased criticism/commands, limit setting, supervision/monitoring, relationship building), methods to model and prompt new skills and positive behaviors, and specific reinforcement (e.g., structured token economy system, increased attention to positive behavior and decreased attention to negative behavior). A recent randomized clinical trial also demonstrates the effectiveness of parent training that includes

prevention, teaching, and management strategies.[105]

Programs with Multiple PBS Components

Several books have been written for professionals and parents specifically about parenting and positive behavior support, combining these different features. They include resources for professionals and parents. The first known resource related to family PBS was *Families and Positive Behavior Support*[106], which included practical applications of principles, case studies, and preliminary research in family contexts. Hieneman, Childs, and Sergay[107] made this information accessible for parents in a self-guided problem-solving workbook that also offers suggestions for universal supports. Durand and Hieneman[108] outlined a similar process for professionals working with families entitled *Positive Family Intervention* (that also includes cognitive-behavioral strategies to overcome parental pessimism as a barrier to implementation). Durand[109] wrote *Optimistic Parenting* to make these approaches accessible to parents and added components of mindfulness and family social support. Finally, as mentioned earlier, Dunlap and colleagues[102] have produced a *Prevent-Teach-Reinforce for Families* manual written for practitioners working with families that outlines comprehensive assessment and contextualized intervention approaches for home and community settings.

RECOMMENDATIONS FOR PRACTICE

Over the years, ongoing research and field-based intervention with families has led to an increasing number of evidence-based clinical practices[110]. The way in which those practices are organized, selected, and delivered may be informed by both the principles of PBS and the growing body of literature on effective family support approaches. We offer the following recommendations based on this review:

Quality of life outcomes

Ensure that the goals of intervention are focused on quality-of-life improvements and fully embraced by the family – that they have social validity and contextual fit. Align goals with the families' strengths, resources, needs, priorities, preferences, supports, and stressors. This means guiding, rather than directing, goal selection via processes of person and family-centered planning.

Family engagement

Engage all relevant family members and others whose involvement could influence the outcomes, valuing their input and rights as decision makers. Ensure their involvement in all aspects of the process of goal identification, assessment, plan design, implementation, and evaluation. Empower families to apply the principles (rather than just procedures) of PBS and become collaborative problem-solvers.

Comprehensive assessment

Conduct structured, comprehensive assessments to develop a valid understanding of immediate patterns and broader ecological variables affecting behavior within the family. Use the coercive family process[95] framework to help families understand reciprocal interactions that may be maintaining problem behavior. Develop and utilize assessment tools[36] to effectively and efficiently capture variables precipitating and maintaining behavior within families.

Support strategies and interventions

Develop support strategies and interventions based on the assessments that are truly

individualized to children, parents, families, and the contexts in which they live. Use the patterns identified and the categories of proactive, teaching, and management strategies to scaffold plan design and as framework for selecting services. Help families select relevant, evidence-based strategies that fit their needs (rather than simply adopting programs or procedures to which they are exposed), encouraging individualized, creative solutions that are aligned with families' goals, values, and culture.

Monitoring fidelity and outcomes

Rely on objective information to assess the fidelity of plan implementation, increases in desirable behavior, decreases in problem behavior, and changes in quality of life. In addition to using clinical judgment and standardized tools, create and use behavioral anchors to structure observations and interviews. Engage parents in evaluating progress, combining simple subjective ratings and feasible recording procedures to capture of specific, meaningful outcomes. Focus data collection not only on child behavior or parental skills, but also overall family functioning.

Tiered programs

Embrace the ecological multi-tiered conceptualization of intervention. Recognize that supports may be focused on the child within the family system, parent as a conduit for change, family as a whole, and/or broader support systems. Establish tiered programs that offer information and resources on PBS to all families, more tailored supports for those at risk or struggling, and intensive individualized assistance for those with the most significant challenges. Develop methods for "triaging" families, assessing their response to intervention, and transitioning within a continuum of services.

FUTURE DIRECTIONS

Positive behavior support offers a useful framework for selecting, integrating, and evaluating evidence-based behavior support practices. The focus on lifestyle enhancement and engagement of support and service providers increases the likelihood that interventions will be readily adopted and sustainable. Comprehensive assessments of both contextual issues affecting behavior and functions maintaining interactions among family members allows the tailoring of strategies to family needs, thereby increasing their effectiveness. Finally, employing proactive, teaching, and management strategies within typical family routines offers a conceptually sound and easily adoptable approach.

These features are evident in family-based intervention both within the PBS literature and broader parent education and support programs. What appears to be missing is a comprehensive, integrated model of service delivery that embraces all features equally. This gap may, in part, be due to a few barriers. First, families whose children may be having behavioral challenges have often been viewed as the problem, or as recipient of services, rather than true partners.[111] Current best practice in behavioral intervention and family support emphasizes respect for the strengths, resources, needs, priorities, and perspectives of all participants, with interventionists embracing a more facilitative role.[112] Unfortunately, these values are not always evident in practice.

Second, professionals from different disciplines have often worked within their own theoretical and pragmatic "silos", making fusion of knowledge and practices challenging.[113] To bring about lifestyle change, PBS often requires the integration of a variety of services and supports, but it has not always been clear how to make this integration feasible. Wraparound process and strengthening systems of care[75, 79], must therefore become a fundamental part of behavior

support within family contexts.

Third, families who need support most are often stressed and discouraged, making them less responsive to education and intervention.[114] This barrier has been addressed through 'adjunctive supports' such as respite, social support, and additional therapies in parenting programs.[115] More recently, cognitive behavior therapy techniques such as optimism training[17, 108], mindfulness practice[116], and related interventions such as *Acceptance and Commitment Therapy*[117] and Cognitive Behavioral Family Intervention[118] have been more fully embedded within behavioral intervention with families. These approaches not only address behaviors of concern, but help parents overcome emotional barriers to implementation of the plans.

And finally, PBS and other comprehensive interventions may be viewed as highly complex and time-consuming, driven by intensive data collection and circumscribed procedures that may seem difficult to implement fully.[119] To be acceptable and feasibly adopted, PBS's core components must be distilled and packaged within user-friendly resources that are readily accessible to families and professionals supporting them (see examples of brief resources on apbs.org-families). Progress is clearly being made in integrating PBS features into family-based behavior support, but more work needs to be done to bring a comprehensive approach to complete fruition.

Ethical approval: This article does not contain any studies with human participants or animals performed by any of the authors.

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The Power of Collaboration through Behavioral Assessment and Treatment

Stacey Keilman, LCSW, and Lindy Mishler, MS

Abstract

Torrance State Hospital (TSH) provides in-patient services for individuals with severe and persistent mental health needs. This article presents the admission, assessment, and treatment of a 55-year-old Caucasian man, referred to as DS with Intellectual Disability, Schizophrenia, Chronic Paranoid Type, and Depression Not Otherwise Specified (NOS). The initial assessment indicated significant trauma symptoms in combination with undetected medical issues. However, treatments delivered at TSH did not result in a clinically significant reduction in problem behavior. A Functional Behavioral Assessment (FBA) was then completed to understand the significance of DS's behaviors and provide strategies and supports that would be beneficial to reduce the impacts of these actions, primarily in the hospital setting. Direct and indirect data determined that the strategies resulted in a significant decrease in behaviors while at TSH. Similar improvements occurred in relationships with other patients and staff.

This article discusses the collaboration between State entities and the clinical implications of the assessments conducted.

Case Presentation

DS is a 55-year-old, single, Caucasian male with a long history of admissions to community and State hospitals. He was initially admitted to Torrance State Hospital due to assaulting a nurse in a medical facility where he was seeking treatment for an unknown medical issue. Upon admission, DS exhibited perseveration on thoughts which included staff was going to cut off his testicles or people were attempting to steal his items and keep them from him. He also showcased significant anxiety due to not seeing his sister, with whom he previously had a close relationship. He was then transferred to TSH's psychiatric unit due to suicidal threats, self-injurious behaviors, and a significant regression in self-care skills. Once on the psychiatric ward, staff described his behavior as impulsive and physically aggressive towards other patients, staff, and property. This included kicking, shoving, or charging at other patients; and hitting, biting, or spitting at staff. He had also thrown food and drinks; thrown or flipped tables; punched the walls; and often fell asleep laying on the floor, preventing others from passing. DS also displayed self-injurious behaviors such as hitting his head against something, scratching himself, and throwing himself into a wall. In addition, staff observed DS becoming more agitated after visits or phone calls with his sister. He would showcase refusal behaviors with staff requests for taking medications or other task requests during these times. During the initial presentation and throughout his hospital stay, DS did not make staff aware if he was experiencing any pain, as evidenced by his lack of expression when he experienced bleeding and lesions from extreme jock itch, significant dental issues, and a corneal abrasion he received as a result of a fight with another patient. Past medical issues included urinary retention and acute renal failure, benign prostatic hyperplasia, GERD, hypertension, kidney stones, hypercholesterolemia, and Chronic Obstructive Pulmonary Disease (COPD).

Evaluation, Treatment, and Silos

Upon reviewing the referral information and prior records; it was identified that DS had a full-scale Intelligence Quotient (IQ) score of 56 from testing administered in early adulthood. This prompted consideration into potential involvement with other systems of care, triggering a conversation with DS's county mental health agency to identify historical information. This review identified that DS was involved with various community resources in the 1980s but was virtually unknown to the mental health/intellectual disability systems until 2006. Further, there was no agency involvement from 2006 to 2016. The mystery of how he maintained in the community for decades without involvement from the various human services systems required additional information since this could help develop strategies, supports, and resources to aid his discharge to community living.

Trauma

Shortly after hospital admission, a Torrance clinician conducted a comprehensive biopsychosocial assessment utilizing DS's sister as the primary source of information. The information gathered during this process uncovered medical issues and a significant change in his support system. Since his previous discharge in 2007, he lived with a caregiver for several years. During this time, he suffered some medical issues, including kidney stones. The arrangement with the caregiver ended, leading him to his psychiatric decompensation and hospitalization. This incident and the tragic loss of his mother in 2006 became two significant traumas affecting his stability.

Treatment

As a result of DS's self-injurious behaviors, he had been placed in several physical holds (a method of restraint with the outcome of purposely limiting physical movement), and a one-piece jumpsuit was ordered to be worn for his protection. His mood vacillated from withdrawn to irritable. At times, he was verbally and physically aggressive. He would become fixated on things and place himself on the floor when matters did not go as expected. He displayed the same perseverations as previously exhibited, and that he was going to die. He injured himself on three occasions by gouging at his wrists with a colored pencil, burning himself with a lighter, and attempting to cut off his genitals. He was an elopement risk during this time as well. The TSH Treatment Team had attempted various interventions to assist DS in gaining and maintaining safe behaviors, but he was not making significant improvements. The staff were demoralized over the lack of progress he was making, and DS expressed feelings of hopelessness. It soon became clear that the psychiatric interventions and strategies that TSH and staff had historically put in place were not effective on DS. Moreover, there was a need to consider other options.

Merging the Silos

When examining the health needs of people in Pennsylvania, the State health system tends to categorize by the individual's cognitive and psychological, medical, and physiological needs. These divided mental, physical, and behavioral health sectors often complicate thorough treatments as a result of each operating independently from one another. Furthermore, there is no system in place where they can adequately share information across territories. Although this is not a new issue, its complexities have increased over time, causing holes where treatments are concerned. To begin the initial steps in merging the silos, the Office of Developmental Programs

started the Capacity Building Institute (CBI). Torrance State Hospital (TSH) staff were invited to join a select group of professionals to meet with the intended goal of sharing philosophies and treatments while ultimately braiding together the mental, physical, and behavioral health territories. During these meetings, case presentations became a joint exercise for staff to share their entities' experiences and successes. It also provided a forum where other groups could recommend treatments or strategies that may not have been previously considered to improve the patient's treatment and address system issues. DS was one of the cases TSH chose to share due to his medical, psychological, and behavioral complexities.

One of the presentations by the Bureau of Supports for Autism and Special Populations (BSASP) was about the process and benefits of Functional Behavioral Assessment (FBA). It was explained that FBA is an evidence-based practice comprised of data collection to understand and recognize the purpose of specific behaviors exhibited by an individual. Once identified, the treatment team can decrease triggers and develop tailored interventions to eliminate problematic behaviors. In addition, the FBA is versatile because it can be used with anyone, in any setting, for any behavior.

Although TSH did have staff trained in the process of FBA, the general practice was not completed routinely, since this approach differs from the typical psychiatric treatment that has long been in place at TSH. Although treatments in State hospitals can be successful[1], their interventions historically focused on mental health treatments[2] rather than routine use of behavioral interventions to identify and decrease problematic behaviors. Since mental health treatments for the acute population have a significant focus on behavioral reduction rather than teaching new skills, interventions tend to be reactive rather than proactive, leaving the hospital staff in a cycle of crisis rather than proactive mitigation. To help address this issue, TSH

requested BSASP complete an FBA on DS. Simultaneously, they also encouraged their staff to be trained in the FBA process, challenging the historical belief of enacting the otherwise unconventional therapeutic strategy in the state hospital setting and breaking down potential cross-system barriers.

Functional Behavioral Assessment[3]

Two clinicians from BSASP were assigned to complete the FBA at TSH for DS. The first step was to gather information about DS's behaviors. This indirect and direct information was collected through rating scales, assessments, direct observation of DS, interviews with hospital staff and DS's relatives, archived incidents, as well as record reviews. TSH freely provided access to the necessary people and resources for the BSASP staff to obtain the necessary information to be as comprehensive and holistic as possible. Using the information gathered on observed target behaviors, BSASP clinicians designed a customized data sheet for staff to collect additional information. This included the behaviors identified with the most significant and what occurred before and after the behavior. For accurate data collection and consistency across staff, it is considered good practice to ensure that the staff collecting the data have a thorough understanding of the expectations for recording the information. To assist with this, all staff were trained in using the datasheet prior to doing so. However, during the clinicians' initial analysis of the raw data, it was identified that there were still variances in the data being collected. As a result, both BSASP and TSH staff met to discuss confusion and revised the data sheets to make sense to the hospital staff to ensure accurate data collection. These revisions were proven successful after the next data set was analyzed, as evidenced by consistencies across staff in the raw data reviewed.

After collecting enough data to accurately represent all variables, BSASP staff graphed and analyzed the data to create a visual story of what the staff had been seeing over the course of the data collection period. Once developed, the graphs were compiled into a report. Without presenting their own hypothesis, BSASP presented the report to TSH staff and prompted conversation while encouraging staff to develop their own hypotheses based on what they were seeing in the data. Ultimately, TSH staff were able to use the visual analysis to develop their own story of what was occurring with DS, aligning with what BSASP hypothesized before meeting with the team. These similar observations were the foundation necessary to develop individualized recommendations.

Strategy recommendations are supports, strategies, interventions, and treatment recommendations grounded in information gathered and analyzed through the FBA process. They are completely reliant on accurate data, thorough data analysis, and hypotheses developed. Due to the quality put forth in the aforementioned steps, BSASP staff were able to identify the contributing conditions to DS's problematic behaviors, how they can be addressed, any skills that needed to be taught, communication and social skill barriers, and how the environment and people were responding to DS's behaviors. This resulted in developing operational definitions of the target behaviors, hypotheses of the functions of those behaviors, behavioral outcomes, and ideas for antecedent (before the behavior), replacement (during the behavior), and consequence (after the behavior has been completed) strategies. Although the strategy recommendations were linked to the hypotheses formulated from the indirect and direct data collected, they were also developed based on the ability of staff to complete them. Thus, a collaboration between BSASP clinicians and TSH staff was essential in developing and solidifying the final recommendation section. These comprehensive recommendations were later revisited to ensure they were

effective and produced the intended results.

In order to shift the staff's responses from reacting to a crisis to being proactive and mitigating risks, a Crisis Intervention Plan (CIP) was also developed. Using the information gathered through the FBA process, BSASP staff were able to recognize the situations that could be triggers for DS and precursor behaviors. As a result, a CIP was developed that included triggers to a crisis, details to assist in delineating the settings in which DS would be in and identify de-escalation techniques for the TSH staff to implement.

The FBA process not only is designed to develop a list of strategy recommendations and CIP, but it can also be a means for identifying information otherwise undiscovered through its in-depth data collection and assessments. During the completion of DS's FBA, interviews with DS and his sister identified that he had experienced more severe trauma than previously known. Some traumatic events included the deaths of multiple loved ones, including both of his parents and two close friends. He also experienced severe physical abuse from his previous girlfriend's children. Therefore, a Trauma-Informed Care (TIC) approach was critical to helping DS recover. Without the FBA, the central information regarding trauma would have continued to be missed and not addressed.

Conclusion

Following the FBA, TSH's treatment team began to see DS's progress in maintaining safety. His mood significantly improved, and he did not present any self- injurious behaviors over time. In addition, his sister was actively involved in his treatment planning, including providing historical information that assisted in medication adjustments. Over the last few months at TSH, DS had gone on day passes with his sister which had gone well and demonstrated that he was ready for

discharge. DS was ultimately discharged to a group with supports in place to assist him in maintaining stability in the community.

It was not only DS that had benefited from the CBI's collaboration. TSH staff experienced benefits as well. Through the FBA process, a data-driven, detailed, and thorough set of recommendations and strategies was made available to support the direct care staff. Torrance leadership supported staff to work with DS, setting a standard for staff to work towards and providing emotional support in times of stress and pressure. CBI became a champion for TSH and partners to come together, without the previous barriers and silos, to identify what DS needed to regain stability and return to his life in the community. The outcome for DS was a great success and demonstrated a complex culture evolution within the State hospital environment from the long-standing pure psychiatric treatment to eventually, total immersion with a data-based behavioral approach. Not only does this experience show the evolution and treatment progress of TSH, it also reflects the importance of collaboration from various stakeholders to meet individuals' complex and unique needs to ensure their long-term success.

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Biographies

Stacey K. Keilman, LCSW: Stacey has been working in the field of human services for 17 years. Her experience has been focused in the areas of substance abuse and mental health treatment. Her various roles have included assessment, treatment planning and intervention, crisis de-escalation, case management, social work administration, community discharge planning, forensic administration, and hospital administration. Stacey has held several leadership positions at Torrance State Hospital including Social Work Supervisor, Social Work Manager, Forensic Unit Director and is currently the Chief Executive Officer (CEO). Stacey is a strong advocate for the individuals served at Torrance State Hospital and embraces the Recovery Model.

Lindy Mishler, MS began working as a Clinical Consultant for the Bureau of Supports for Autism and Special Populations, Office of Developmental Programs in 2014. Lindy started her career as a Therapeutic Staff Support (TSS), where she discovered her passion working with children with autism. Since then, she has worked in a variety of positions, including direct support professional, vocational development, and has overseen Pennsylvania's waiver programs in multiple agencies. Through these experiences, she has been able to expand her knowledge and experiences into other populations including adults with autism, traumatic brain injuries, other physical disabilities, and Mental Health diagnoses. She has a master's degree in Psychology with a concentration in Applied Behavioral Analysis.

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Putting the Positive in Behavioral Support: Considering the Role of Autonomy, Mastery, and Purpose

Stacy L. Nonnemacher, Ph.D.

Introduction

We have made many strides in the understanding of effective behavioral support. Gone are the days of aversive strategies and interventions in the name of behavioral modification. We welcome the marriage of respectful, person-centered supports and science leading to long-lasting, meaningful changes in a person's life.

Let's Get on the Same Page

Everything we do is behavior. You are reading this article right now, that is a behavior. You may have used your mouse to scroll or picked up your coffee to take a sip while reading this article. These are all behaviors. At some point, we humans gave the word "behavior" a bad name. We all have behavioral repertoires, some work and some don't support how we define living a meaningful life. And when someone we support is engaging in behaviors that may be interfering with their ideal functioning, we often say that the behavior is problematic and challenging. These descriptors are accurate but what we need to reconceptualize is who finds these behaviors problematic or challenging. Oftentimes, what the person is doing may be working for that person, while also being dangerous or disruptive. It may be their best attempt at getting what they want because they have no other functional way to communicate or may have historically been getting what they need as a result of engaging in this behavior. In a sense, this is working for them. However, the supporters of the person may find the behavior is not working; they are doing their best to provide support so that the person does not have to self-harm, hurt others, engage in property destruction, etc. to get what they need. In the end, the behavior is problematic or challenging to the people who support the person rather than to the person engaging in it to get their desires met.

Evolution

While much can be said about the evolution of behavioral support, for the purpose of this article, it is important to note that as the disability field has shifted from institutional to home and community support, we have worked to find better ways to support people across the lifespan. Behavioral science has moved from its early roots in theory to a focus on actionable

consequences or finding ways to minimize behaviors, towards embracing a more person-centered, proactive approach that emphasizes the importance of quality of life and skill-building. Like any science, we continue to change and adapt based on what we learn as we practice and use technology to increase the precision of our implementation and research. Therefore, we land in a place where Positive Behavioral Support (PBS) marries the science from years of applied research and the art of individualized, person-centered supports.

Positive Behavioral Support

Positive Behavior Support is an approach to supporting people in home, school, work, and community environments that combines the principles of applied behavior analysis, implementation science, and best practices from other human service fields. It is characterized by a commitment to collaboration; basing interventions on a thorough understanding of the person and environmental influences affecting behavior; proactive, educative, and functional strategies; making decisions on the basis of objective information; and focusing not just on behavior change, but also on improvements in quality of life.[1]

PBS is predicated on several core features including[1]:

1. **Data-Based Decision Making:** PBS relies on objective data for decision-making. During assessment and through ongoing behavioral support, data is critical to guiding the direction of support.
2. **Collaborative Team Process:** PBS requires the engagement of individuals who are the focus of intervention and all relevant stakeholders. A multidisciplinary team is important to ensuring a holistic approach to assessment and intervention.

3. **Assessment of Contexts and Functions:** PBS requires objective and thorough assessments to develop effective, individualized support plans. Collecting both indirect and direct data to highlight patterns in function and contexts while also capturing broader physical and social ecology that might be contributing to the behavior is at the heart of PBS.
4. **Multicomponent Plans:** PBS plans include multiple components that are linked directly to the patterns identified in the assessment. Plans should include:
    a. Preventative strategies.
    b. Methods to teach replacement behaviors and other skills.
    c. Interventions that focus on reinforcing positive behavior rather than problem behavior.
5. **Lifestyle & Quality of Life Change:** PBS is driven by the goal of improving people's quality of life. Finding purpose and meaning while focusing on improving advocacy, relationships, community engagement, productivity, and health and safety sets the stage for behavioral supports to work.

A Focus on Lifestyle and Quality of Life

"It is motivating when meaning and purpose are given to treatment beyond just avoiding offending behavior." James Haaven[2]

While James Haaven speaks of treatment for persons who have sexually offended in this quote, it is a poignant consideration for all supporters. Avoiding the behavior of concern and focusing only on fundamental, physiological needs like food, shelter, and water ignores the importance of

meaning and purpose as motivating qualities for someone to show up and have the drive to change – whether that is intrinsically or extrinsically motivated.

In fact, some assert that people who have their psychological needs to be competent, autonomous, and related to others met are also more motivated to grow and change – known as Self-Determination Theory[3]. This theory posits that physical and social environments that focus on meeting these psychological needs strengthen intrinsic motivation. Of course, there are times when extrinsic factors like rewards and praise are needed, but in a behavioral approach to treatment, we can do better in creating environments that focus more on getting these psychological needs met as a critical function in behavior change.

Dan Pink[4] translated the Self-Determination Theory and other similar theories and research into a recipe of three easily understood ingredients that focus less on extrinsic desires and more on creating opportunities to foster autonomy, mastery, and purpose. We need to get better at embracing these three notions as central components of behavioral support.

Including Autonomy, Mastery, & Purpose in Behavioral Support

"Control leads to compliance; autonomy leads to engagement." Daniel Pink[4]

- First, ask yourself how much *autonomy* someone has in their day. Taking inventory and seeing where someone is "decision deficient" could be very telling to how they are showing up and perhaps asserting themselves to seek control in a life over which they may feel they have no control.
- Second, *mastery* or being good at something or just having the skills to accomplish a task motivates one to show up time and time again even on the days you don't feel like doing that

task. If you focus on ensuring that people have the skills they need to be successful, they will engage and make progress.

- Third, having a *purpose*, contributing to a larger goal, connecting with others, or sharing a common goal that is outside of ourselves bolsters the motivation of those who are autonomous and who have the skills to be successful. Finding meaning and purpose or something that a person is passionate about can make those other things bearable and more tolerable.

Conclusion

So, let us eliminate goals that focus on avoidance, and support plans that seek only to decrease challenging behavior. Instead, let us work on creating a system of support that seeks to provide opportunities for autonomous living where the person has the skills to be successful and finds or has purpose and connection outside of themselves. If we ground our behavioral support plans in the understanding that there is more than just minimizing, decreasing, or disruptive behavior; we can increase the chances that overall well-being and psychological health will be impacted. Consider James who was supported in the community with many restrictions to minimize his use of technology and social media due to a court order. James was described by his team as "unmotivated" and "resistant" to treatment. In fact, most of James's day was spent playing video games and arguing with his staff about what he should be doing instead. James had a well-written Behavioral Support Plan (BSP) and while the team was able to put good antecedent and consequence strategies in place, they struggled to engage James in building skills like Activities of Daily Living (ADLs) and to follow through with things like scheduling his day. It wasn't until a new, weekend staff person was hired that this began to change. The new staff person was the same age as James and talked with him as a peer. They talked about new things they could do

together on weekends like go to clubs and bars. Long story short, the new staff person didn't focus solely on correcting, controlling, and redirecting James. He gave James options to try new, age-appropriate things to occupy his free time (and he had a lot of it!) In turn, James paid more attention to his hygiene which prior to this, was one of the points of contention between James and his staff. We know that never ends well because, as in this case, the behaviors that were being addressed are looked at as "quality control.[5]" Unfortunately, this new staff person left his position as so many direct supporters do, and the focus on meaning and purpose was never written into James's BSP, skills were not generalized, and the team returned to focusing on avoidance and decreasing challenging behavior. Thus, the team did not capitalize on the momentum of real behavioral change driven by a focus on autonomy, mastery, and purpose. We all know where that left James. Let this be a lesson to us all. Taking a behavioral approach in the treatment of challenging or interfering behaviors should consider both the art and science of support and an understanding and utilization of the PBS model to meet the needs of people like James and of those around him. Considering factors like autonomy, mastery, and purpose like James's staff unknowingly did will provide the basis for engaging someone when teams feel all hope is lost. Acknowledging these positive changes and what is most influential in that change is important – even more important is to take what you learn and continue incorporating that in the supports for that person.

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Biography

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