POSITIVE BEHAVIOR SUPPORT ASSESSMENT (PBSA) GUIDE

The PBSA is the cornerstone of BSC work. Through its development we hope to gain a holistic and dynamic perspective on the many factors that contribute to an individual's current position in the world and the important variables that affect their behavioral communication. Without the PBSA there can be no Positive Behavior Support Plan (PBSP).

A BSC may bill up to 20 units for the initial/annual formulation and an additional 20-units/ISP year for any rewrites as deemed clinically necessary.

I. Identifying Information: Every line of this section is required by the Department of Health. Do not leave any blanks:

INDIVIDUAL'S NAME:	**JACKSON CLASS MEMBER:**
DOB:	**LAST 4 OF SSN:**
INDIVIDUAL'S ADDRESS:	**INDIVIDUAL'S PHONE CONTACT:**
GUARDIAN:	**GUARDIAN CONTACT:**
RESIDENTIAL AGENCY:	**CCS AGENCY:**
CASE MANAGER:	**CASE MANAGER AGENCY:**
OTHER PROVIDERS:	**REGION OF RESIDENCE:**
ANNUAL ISP DATE:	**DATE OF REPORT:**

The remainder of this guide follows the format of the PBSA Template:

II. DIAGNOSIS

- **a. Current Diagnosis**
- **b. Previous Diagnoses**
- **c. Current Relevant Medical Issues**

BSCs are not permitted to diagnose individuals on the Waiver. The information in this section must come from another source – e.g. the ISP, the psychiatrist etc. Please note the source. A BSC can however add a Diagnostic Impressions section here that explicates any differences of opinion you may have with the diagnoses (in fact, this is encouraged).

III. CURRENT MEDICATIONS (ATTACH MARS)

A complete listing of the medications an individual is taking as of the date on the report. Name, dosage, administration times, and why prescribed should all be included.

IV. REFERRAL INFORMATION

This is how a BSC describes how they became involved with the case, and where the first information came from.

- **a. Reason for Referral**
- **b. Referral Source**
- **c. Individuals Contributing Information**
- **d. Record Review**

V. RELEVANT FACTOR: INDIVIDUAL ATTRIBUTES

- **a. Biological or Physiological Factors**

Take some time here to define any physical/medical diagnosis(es) the person may have. Remember your audience. The staff may know that a person has Cerebral Palsy but do they know what CP is? State the condition and then give a plain language definition of the condition and possible symptoms. Do the same with any/all medical and psychiatric conditions. Stay basic but give the reader an idea of how the condition may affect behavior.

b. Problem Solving Capacity and Means

Is the person normally oriented to identity, time, place, season, activity? Does the person understand the normal course of the day, week, month, and year? If the person can follow directions/requests – is there a limit to the number of steps they can handle at one time? Does the person try to figure out problems on his or her own? If so – how effective are they?

c. Intellectual Status

Can the individual make assertive choices as to what they do/do not want to do? How can they express this choice? If they can – do they? If not, why? Once the person makes a choice, are they able to effectively follow-through? Can they transition from one activity to another without significant difficulty?

d. Cultural Issues

Are there specific cultural identifiers or group affiliations that the individual uses or subscribes to that are pertinent to the individual's support?

e. Spiritual Beliefs

Does the individual have any religious or spiritual preferences? Are they able to engage in these activities or do they need more support? Does the individual have any preferences in their appearance or the appearance of their surroundings? How do we know these things – are they telling or are we guessing?

VI. RELEVANT FACTOR: RELATIONSHIPS AND ASSOCIATED SKILLS

a. Communication

How does the person communicate? – Both at their best and at their worst. Verbal abilities and how they change depending on stress. Non-verbal style of communication is also important to note. Interface with and refer to the SLP and SLP plan if one is available.

b. Social Competence

Does the person seem to be interested in social activities/contact? What do they seem to prefer in social interaction – one-to-one or groups? Does the person have knowledge of stranger/acquaintance/friend and how these roles change over time? Does the individual understand the progression of conversation and some basic social scripts? Does the person display adequate social boundaries and limitations? For individuals who cannot/do not speak or directly communicate try to describe how they interact with the world and who they seem to prefer from a social/support perspective.

c. Self-Regulation

Everybody gets stressed and everybody has his or her own ways of de-stressing. Some techniques are effective and non-harmful (deep breathing). Other methods may be effective but potentially harmful (punch the wall). In this section try to list the different ways the person seems to regulate their own needs/comforts. Divide into sub headings of 'Most Adaptive'; 'Less Adaptive' and 'Potentially Harmful'.

d. Emotional Status

Think 'affect' more than mood. Affect is what you can observe in a person's countenance and body language that may give a window to their emotional world. Does the individual display a wide variety of emotion or are they 'restricted' in their affective appearance? Does their affect match their likely emotion or is it incongruent (laughs when encountering a sad event)? How does the person handle a variety of emotions? Can the person verbally express a variety of emotions or is their emotional language restricted to 'happy and sad'. How does the person react to emotional distress?

VII. RELEVANT FACTOR: ENVIRONMENTAL

Environment is the single biggest contributor to any organism's behavior. Give some space to each of the supportive environments the individual utilizes – residential, day program, school, employment, natural supports. Provide a description of each of these environments and the components that contribute to their success or failure. Some brief recommendations for improvement may be made but a full exploration of your recommendations should be reserved for the Positive Support Plan.

a. **Settings**
b. **Social Density**
c. **Lighting and Noise**
d. **Movement**
e. **Opportunities to Exercise Independence**
f. **Opportunities to Engage in Participatory Activities**
g. **Perceived Level of Satisfaction**

Think of the five senses. Does this client have any limitations in any area? Do they seem to not like certain environments or really prefer other environments? What are the qualities of these environments (crowded, loud, bright etc.) that may influence these preferences? If there is an OT on the team – read their plan, talk to them about these areas.

VIII. RELEVANT FACTOR: TRAUMA-INFORMED CONSIDERATIONS

The core principles of trauma-informed practices apply regardless of a person's known/unknown history of experiencing discrete or multiple trauma(s). In some cases, the specific trauma(s) a person has experienced may be a clear factor in building supports. In other cases, perhaps without known/divulged trauma, these considerations may be more generalized but still highly relevant to helping a person build a life of confidence and belonging. Considering the information you've compiled above – what factors below seem the most relevant as you build toward planning for skill development and quality of life? While not each and every item or question below may be relevant – address the ones that are and add any you see as missing.

a. **Safety**

Physical, psychological, social, or spiritual considerations. Are there any basic safety concerns in the person's home, work, or social environments? Might there be a need for trauma-specific counseling or pre-counseling (i.e., relationship building, stress-management skills)? Would the individual benefit from skill-building related being able to improve self-care skills? What level of physical contact/personal space seems to be preferred?

b. **Trustworthiness/Transparency**

How might the individual's history impact her/his/their level of trust in others? (e.g., to be treated well/kept safe, to be listened to, to be included).

c. **Peer Support/Relationships**

How has the person been included or marginalized in social, family, or professional relationships? Does the individual have at least one person he/she/they can talk to privately? Is the person part of any simple social/peer group?

d. **Collaboration/Mutuality**

Does the person feel like they are part of their own team? Can we improve how we include the person in support planning? Do you think the person has been included as much as possible in this process of assessment? If yes, how might it expand further? If not, what may be first steps to improvement?

e. Empowerment, Voice, Choice

Is the person's voice present in team meetings? In their household? In other environments? How can the person experience more power in their own life or support planning? Are there missed opportunities for choice-making?

f. Cultural, Historical, and/or Gender Issues

Are there any factors related to cultural, historical, or gender issues that have not been addressed? The intersection of trauma with other aspects of marginalization may more easily lead to re-traumatization and disempowerment.

IX. EFFECTIVENESS INDICATOR: COMMUNITY INTEGRATION/QUALITY OF LIFE

Being able to safely access the community and engage emergency services are highly important parts of living an integrated life. Can the individual safely navigate the community? If not- what level of support is necessary to help them get to where they want to go? Do they need one-to-one support due to safety concerns? Do they need help with street safety? How can they access the community services, activities etc. that they prefer? How can they communicate these needs/preferences? Can they effectively access emergency support (e.g. 911)? If emergency response is necessary –how might they respond to the emergency personnel?

a. Discussion/List of Opportunities to Participate in a Range of Experiences, Events, Settings

b. Discussion of individual's overall satisfaction

Does the individual seem to like what is happening around them?

X. EFFECTIVENESS INDICATOR: SKILL DEVELOPMENT

a. Discussion of Current Skills

This is where an acknowledgement of capacities and understandings should be illuminated, even if the outcome of the behavior or utilization of the skill set results in something the IDT does not agree with. Many individuals develop effective skills in the context of deprivation, rejection, and restriction; these skills should be given credit and described.

b. Focus on Communication and Social Skills

A description of skills in the context of communicating with others, whether it is to communicate a want or need, obtain a preferred item, or to express an opinion is an appropriate transition from the assessment to the plan.

If you do not know where to focus ideas for planning – START HERE.

c. Relationship to Challenging Behavior (i.e. Possible Replacement Behaviors)

This is a root of the Positive Support Plan. Some basic beginning ideas on how the person may ask for what they need or how staff can learn new skills to lessen the frequency and severity of the behavior. Staff can learn to read the 'build-up' to the behavior and intervene at an earlier stage. No need to get too detailed here – save it for the PBSP.

XI. EFFECTIVENESS INDICATOR: CHALLENGING BEHAVIOR

BSC work is not just about 'reducing the frequency of challenging behaviors'. It is about being a voice of advocacy and negotiation with/for the person you support. BSCs do this by making sure they look beyond behaviors towards the potential for increasing a person's sense of identity, purpose and meaning in their life.

Perhaps a better way to think of this is "Behaviors that Challenge Our System". The challenge is ours – to be better at creating a meaningful life for the person, to adjust the system, and to understand the communication underlying what we can observe. In many

ways, a person's so-called challenging behavior may be functional – it serves a purpose – but may not be 'appropriate'. The job is not to 'squash' or eliminate the behavior as this does not address the unmet need. Odds are that the pattern will simply pop out again somewhere else in the person's life. By focusing on unmet needs and support rather than on numbers of occurrences and control we can take behavioral data and use it in a person-centered fashion.

That being said, it remains useful in certain situations to collect clear and objective behavioral data. The following is the method we use to compile a Functional Assessment.

Start by picking 1-3 'challenging behaviors' that the individual may demonstrate. Pick the ones that seem to be the biggest barriers to growth – that get in the way of the person leading the life they want to live. It is important to get clear feedback from staff and family about this: find out what the people most familiar with the individual see as the biggest challenges. If at all possible – always get the individual's input into this as well.

a. **Description of Behavior(s)**
   A concrete, specific and detailed description of the behavior. Don't get into theories of why or how etc. Simply describe the behavior. The goal is to be clear enough that a person reading it would be able to fully act out the actions without ever seeing it.
b. **Frequency**
   What is the best timeline by which to measure the behavior/pattern of concern? Hourly? Daily? Monthly? Annually? Are you hoping to count every single occurrence or just that it happened over the course of a day/week/month? The units and stipulations of measurement depend on the nature of the pattern of concern.
c. **Severity**
   Simply state how severe the behavior is occurring over the few months preceding the assessment. If this is an update of an assessment try to include previous year's data as well as current. This could be measured using a continuum in terms of harm (e.g., gesture →fleeting mark →lasting bruise →onsite first aid →needs medical attention) or damage (e.g., monetary cost) or distance/time (e.g., for elopement).
d. **Antecedents**
   This answers the question: 'What makes it more likely that the behavior may occur?' These could be environmental factors, certain activities, weather, types of interaction to name a few. With the smoking example this would likely include items like: just had a meal; just went through a stressful meeting.

e. **Precursors**
   This is the answer to the questions of 'how does the individual build-up to the above described behavior?' or 'how do we know the behavior/pattern is about to occur?' For example – if the behavior was 'smoking a cigarette' the precursors could be: pats pack of cigarettes in pocket; pulls out pack; pulls out lighter; puts cigarette in mouth; flicks lighter; places flame of lighter to end of cigarette. Those more familiar with the person may even know of earlier precursors – like a certain look on the face or a type of deep breath etc. Knowing the precursors can lead to prevention tactics versus intervention tactics – the difference between being proactive vs. reactive. There are times when behaviors occur without clear precursors or 'out-of-the-blue'. In fact, this is the answer you will get most often from staff –"I don't know – it just happens." While this may be

true – do some more digging and you will usually find that there is a 'behavioral chain' of sorts that people didn't even know they knew. If possible – of course ask the client – "Do you know when you're going to do x? How do you know?"

f. Function(s)

For the most part, there are four possible functions of any behavior:

1. *Tangible: …to get an item.*
2. *Escape/Avoid: …to get away or avoid an event/activity/person/environment/ sensory experience.*
3. *Attention: …to gain the attention of someone specific or a specific type of attention.*
4. *Sensory: …to satisfy a sensory need e.g. self-regulation, de-stimulation, hunger, pain.*

PLEASE NOTE: Rarely can any behavior or pattern be pigeonholed into one function. This is a 'best-guess' endeavor that may be helped by asking the person, asking family or direct support professionals, and listening to your gut. In a minority of cases it may be worth it to do a more formal functional assessment using a tool such as the Functional Assessment Screening Tool (FAST) or Motivation Assessment Scale (Durand, 1997)

XII. EFFECTIVNESS INDICATOR: TEAM FACTORS

The BSC is responsible for assessing the IDT's current perspective and understanding regarding relationship, environmental, and activity issues. Team strengths reflecting perspectives, practices, and understandings the BSC finds are consistent with positive behavior support should be noted. Perceived team perspectives, practices, and understandings inconsistent with Positive Approaches should be identified. The needs are then addressed in the PBSP.

a. Current Understanding: person-centered, individual rights/dignity, protection from ANE, understanding ecological context of behavior

The goal of enhanced quality of life is founded on underlying values that are essential to positive approaches. The foundation values are:

1. *Supports and services are person-centered and rely on specialized and generic resources*
2. *Individual rights and dignity are respected and protected.*
3. *Individuals are protected from undue health and safety risks and are free from abuse, neglect, coercion, and exploitation.*
4. *Behavior is understood from a broad ecological context*

b. Areas of Potential Improvement

The BSC contributes to the IDT's holistic understanding of the individual from a current and historical perspective that guides team planning and subsequent support. The individual's family and staff will have enhanced confidence and capacity for responding to challenging behavior as well. This is observed regardless of impact on traditional behavioral topographies.

XIII. RESOURCE ALLOCATION DETERMINATION

In this section the BSC must clearly present the case for how BSC hours will be requested and potentially allocated. This is not meant to be a re-statement of the information contained in the main body of the PBSA but is a brief summation of relevant factors that are clearly supported by the information contained throughout the main body of the PBSA. This relates directly to the completion of the BSCPAR and will ease the Prior Approval process.

a. Clinical Impressions

The BSC is responsible for summarizing their assessed impression of the individual's status, positive support needs, and facilitating a discussion with IDT members. Again, the BSC and team must refer to the Clinical Criteria for on-going services to determine whether prior approval should be requested. The PBSA will be the principal document supporting that decision.

- **b. Clinical Necessity Criteria**
- **c. Fading Factor/Return to Core Hours**
- **d. Complexity Factor**
- **e. Preliminary Risk Screening**
- **f. Crisis Supports**

XIV. SERVICE RECOMMENDATIONS/UNITS REQUEST

- **a. If Exclusion Criteria Met: Statement of other services, trainings, comm. mental health to consider**
- **b. If fulfills Clinical Necessity Criteria: Recommendations regarding BSC service planning, training, visit frequency**
- **c. If Fulfills Clinical Necessity Criteria: Any recommendations for Crisis or PRSC add-ons**

BSC SIGNATURE
WITH TITLE AND CREDENTIALS

DATE

BSC SUPERVISOR SIGNATURE (If BSC is not independently liscensed)

WITH TITLE AND CREDENTIALS