

# Vermont Psychiatric Care Hospital Procedure

## Positive Behavior Supports

Revised: X

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### DEFINITIONS:

**Functional assessment:** Functional assessment is a process for gathering broad and specific information about a patient's behavior in order to identify the function or purpose that the behavior serves. The information gathered in this process is utilized to develop interventions to change problem behaviors and to reinforce new behavior patterns. A functional assessment is the first step in designing a behavior support plan incorporating positive behavioral interventions.

**Type I intervention:** A Type I intervention is the result of a consultation meeting with a treatment team and a member of the psychology service. It utilizes a positive behavioral supports philosophy, which tries to identify problem behaviors and what the patient is trying to accomplish in engaging in them.

**Type II interventions:** A Type II intervention is a formal behavioral intervention addressing a complicated or treatment refractory behavior problem. It includes a consultation meeting with the treatment team to define the maladaptive behavior(s) in question.

### A. OVERVIEW OF BEHAVIOR SUPPORTS SERVICES

The psychology service shall provide a range of behavior supports services that promote acquisition of adaptive, pro-social behaviors and facilitate recovery and help to minimize the occurrence of behaviors which interfere with recovery and community integration. Specifically, the psychology service provides:

1. Behaviorally-informed education and training for staff, including overview of behavior support services in clinical employee orientation;
2. Consultation with treatment teams, including patients, to develop pro-social and adaptive behaviors and to minimize behaviors which interfere with recovery and community re-integration;
3. Assessment of patients exhibiting behavior problems;
4. Psychometric assessments of patients for whom such test data may aid the unit team in determining accurate diagnoses, or designing effective treatment interventions and/or discharge plans.
5. Facilitation of positive interventions to increase motivation in treatment;
6. Assistance in developing interdisciplinary treatment plans to address maladaptive behaviors;
7. Assistance and support in developing and implementing behavioral interventions for patients;
8. Development and implementation of institutional policies related to behavioral interventions; and
9. Evaluation and treatment of trauma-based behaviors.

Behavioral interventions and interdisciplinary interventions targeting maladaptive behaviors shall occur at both the milieu and individual levels. Behavioral interventions shall be based on positive (as opposed to aversive) contingencies and shall not involve

limiting a patient's choices or freedom of movement beyond what is otherwise encountered in an inpatient setting. Examples of behavioral interventions include simple positive reinforcement of adaptive behaviors; social reinforcement and behavioral contracting to increase adaptive and reduce problematic behaviors; modeling, shaping, and coaching of adaptive behaviors; skills training; and systematic desensitization to address anxiety-based behaviors.

**1. Milieu behavior supports services**

Behavioral methods such as instruction, prompting, shaping, modeling, and social reinforcement are inherent in staff-patient interactions in the provision of daily care. Direct care staff members are trained to model and encourage adaptive behavior whether or not those behaviors are specifically outlined in the individualized treatment plan. The psychology service shall provide training, ongoing instruction, and consultation to unit staff in support of these efforts.

**2. Individual behavior supports services**

The psychology service shall provide consultation, interdisciplinary recommendations, and behavioral interventions to address individual maladaptive behaviors upon referral from unit teams.

**B. REQUESTS FOR CONSULTATION**

1. All requests for a behavioral consultation shall come from a treatment team and may occur:
  - a. In the context of routine treatment team meetings (for non-urgent requests).
  - b. On an emergency basis for behaviors requiring more immediate intervention to minimize risk of harm to the patient or others.
  - c. Following notification from the quality assurance department that the patient has met a risk threshold indicating behavioral problems whose intensity or frequency poses a risk to the patient or others or is requiring restrictive interventions (e.g., seclusion, restraint) to prevent harm from occurring.
  
2. The following situations are some indicators of the need for a behavioral consultation:
  - a. Frequent/ongoing need for seclusion, restraint, and/or constant visual monitoring to prevent aggressive or self-harm behaviors that have not been resolved through rapid stabilization or intensive treatment efforts.
  - b. Need for frequent PRN medication administrations to prevent aggressive or self-harm behaviors that have not been resolved through rapid stabilization or intensive treatment efforts.
  - c. Injuries to self or others resulting from an individual's behaviors that have not been resolved through rapid stabilization or intensive treatment efforts.
  - d. Presence of behaviors which are interfering with the individual's recovery or community reintegration.

- e. Deficits in pro-social or adaptive behaviors which are interfering with the individual's ability to benefit from treatment and make progress on life or treatment goals.
- f. Ongoing non-adherence to clinically indicated medication.
- g. Absence of meaningful engagement in treatment.
- h. Problem behaviors related to the presence of dementia, traumatic brain injury or other cognitive / developmental disorders.

### **C. CONSULTATION AND FEEDBACK**

1. Upon receiving a request for consultation, the psychologist assigned to the team making the request will review the patient's medical record and meet with the referring treatment team to discuss the behaviors of concern, identify interventions already tried, identify patient characteristics relevant to treatment (e.g., motivation, strengths) and determine factors potentially contributing to the problematic behaviors.
2. During the consultation meeting, the team shall update the patient's treatment plan to reflect interventions decided upon during the meeting. Interventions may involve activities from any discipline but will be specifically designed to address behaviors.
3. On the basis of this consultation, and any additional assessments identified as necessary during the consultation, the psychologist will develop a comprehensive list of recommendations. Written feedback on consultations is provided to treatment teams within 48 hours of consultation. This feedback may be more extensive than that provided in the initial meeting and may include additional recommendations for the team. Written feedback is maintained in the progress notes section of the patient's medical record.
4. Upon receipt of feedback the treatment team shall review the recommendations and make decisions about implementation of any additional recommendations. New interventions resulting from this review will be included as an addendum to the current treatment plan and integrated into the treatment plan at the next treatment plan review. When integrated into the treatment plan, these interventions will be specifically listed as an intervention under one or more relevant problems and the goal statements for those problems.

### **D. FUNCTIONAL ASSESSMENT ( see *DEFINITION* above)**

1. In the case of some more difficult and/or long-standing behavioral concerns, a more formal functional assessment may be conducted in order to identify those factors, including any history of trauma, that are contributing to the development and/or maintenance of problem behaviors and preventing the development of more adaptive or pro-social behaviors
2. In these instances, the psychology service, with the referring treatment team, completes a functional assessment of behaviors that require in-depth assessment in order to determine the function of the problematic behaviors and arrive at treatment recommendations. This evaluation includes a functional assessment of *each* problem behavior.
3. When a functional assessment has been conducted, a report summarizing the results of the evaluation is completed and submitted to the referring team. The original report is maintained in the patient's medical record.

## **E. DEVELOPMENT OF BEHAVIORAL INTERVENTIONS**

### **1. Type I Behavioral Interventions: (see DEFINITION above)**

In many instances, behavioral interventions may be incorporated into the individual's treatment plan directly following the initial consultation meeting. In these instances, the referring treatment team collaborates with the psychologist on the development and implementation of the interventions. When behavioral interventions are indicated, an instruction sheet for staff implementing the plan will be developed and circulated among appropriate staff. A copy of the instruction sheet will be filed in the treatment plan section of the patient's medical record.

### **2. Type II Behavioral Interventions: (See DEFINITION above)**

For more complex behavioral problems, (e.g., those which require a formal Functional Assessment), a second consultation with the team is held following completion of the functional assessment to review its results and develop behavioral and other discipline-specific interventions to address the behaviors of concern. Written Type II behavioral interventions are more detailed and specific plans which are written separately and maintained in the patient's medical record.

## **F. ORIENTATION AND TRAINING FOR BEHAVIORAL INTERVENTIONS**

1. The treatment team and consulting psychologist shall insure that information relevant to the implementation of behavioral interventions is communicated to relevant staff.
2. The consulting psychologist shall communicate with the treatment mall staff to assure that they are also apprised of behavioral interventions to encourage consistency in implementation across settings.
3. Training in the implementation of behavioral interventions shall be provided by the consulting psychologist or other members of the psychology service to all staff having frequent contact with the patient.
4. All unit staff required to adhere to behavioral interventions shall receive initial and follow-up training. Training includes review of the written intervention as well as practice implementing behavioral procedures via role-play, and shall include relevant procedures and processes for data collection, when indicated.
5. When concerns arise as to the efficacy of a behavioral intervention or the consistent or proper implementation of the intervention by treatment team staff, the psychology service, may consult the Nursing Supervisor to resolve any problem.

## **G. DATA COLLECTION FOR BEHAVIORAL INTERVENTIONS**


1. **Data collection for Type I and Type II interventions:**
  - a. Staff estimates of the frequency and severity of problem behaviors are recorded on a weekly basis.
  - b. The psychologist, with input from the team, will complete this scale during regularly scheduled rounds or treatment planning meetings.

**2. Additional Data Collection for Type II interventions:**

- a. In addition to the data collection procedures outlined above, which provide estimates of problem severity **and perceptions** of frequency, *quantitative* data regarding the frequency of specific target and replacement behaviors (and other indicators of treatment effectiveness, such as frequency of seclusion or restraint) are used to facilitate decisions about treatment revision and/or discontinuation.
- b. Baseline data are collected on relevant dimensions of the behavior or symptomatology, preferably *prior* to implementation of a behavioral intervention. In some cases, and in the interest of expeditious provision of treatment, baseline data may be gathered retrospectively from the patient's Medical Record.
- c. Unit staff members collect data on targeted behaviors as specified in the behavioral intervention plan, using measures appropriate to the behavior, symptom or circumstances. The psychologist, in coordination with the Nursing Supervisor assigned to the unit, shall assure that the staff members responsible for data collection are trained. Data are summarized by the psychologist on a weekly basis in the Progress Notes section of the patient's medical record.

**H. OVERSIGHT OF TREATMENT EFFECTIVENESS**

The psychologist provides updates on treatment progress during team rounds and reviews each behavioral intervention and any relevant data with the treatment team. At this meeting, the team may decide whether to continue current procedures; make procedural adjustment or programmatic revisions; conduct additional staff training; seek additional consultation; or make changes in medical or other disciplinary regimens (in concert with appropriate disciplines.)

Approved by	Signature	Date
Frank Reed, Commissioner of DMH		11/29/16

## Vermont Psychiatric Care Hospital Psychology Service

### Operational Criteria for Referral for Behavioral Case Consultation:

**Clinical criteria that may lead to consideration of a referral for a behavioral consultation include the following:**

- a) Patient has been the target of repeated victimization or bullying by peers.
- b) Patient engages in self-harm behaviors that have not decreased in response to existing treatment team interventions
- c) Patient engages in physical aggression/violent behavior towards other patients or staff that has not decreased in response to existing treatment team interventions
- d) Presence of maladaptive behaviors related to dementia, traumatic brain injury or other cognitive/developmental disorders that have not decreased in response to existing treatment team interventions
- e) Patient engages in maladaptive behavior that actively interferes with community re-integration or placement in a less restrictive setting (e.g. highly agitated or disruptive behavior, threatening behaviors, extremely poor hygiene, sexualized behaviors that put client or others at-risk)
- f) Patient not adhering to medication protocol that treatment team deems necessary for their clinical improvement.
- g) Patient whose maladaptive behaviors have necessitated a transfer to a more restrictive unit.

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10. Behaviorally-informed education and training for staff, including overview of behavior support services in clinical employee orientation;
11. Consultation with treatment teams, including patients, to develop pro-social and adaptive behaviors and to minimize behaviors which interfere with recovery and community re-integration;
12. Assessment of patients exhibiting behavior problems;
13. Psychometric assessments of patients for whom such test data may aid the unit team in determining accurate diagnoses, or designing effective treatment interventions and/or discharge plans.
14. Facilitation of positive interventions to increase motivation in treatment;
15. Assistance in developing interdisciplinary treatment plans to address maladaptive behaviors;
16. Assistance and support in developing and implementing behavioral interventions for patients;

17. Development and implementation of institutional policies related to behavioral interventions; and
18. Evaluation and treatment of trauma-based behaviors.

Behavioral interventions and interdisciplinary interventions targeting maladaptive behaviors shall occur at both the milieu and individual levels. Behavioral interventions shall be based on positive (as opposed to aversive) contingencies and shall not involve limiting a patient's choices or freedom of movement beyond what is otherwise encountered in an inpatient setting. Examples of behavioral interventions include simple positive reinforcement of adaptive behaviors; social reinforcement and behavioral contracting to increase adaptive and reduce problematic behaviors; modeling, shaping, and coaching of adaptive behaviors; skills training; and systematic desensitization to address anxiety-based behaviors.

### **REQUESTS FOR CONSULTATION**

3. All requests for a behavioral consultation shall come from a treatment team and may occur:
  - a. In the context of routine treatment team meetings (for non-urgent requests), or Treatment Plan Meetings.
  - b. On an emergency basis for behaviors requiring more immediate intervention to minimize risk of harm to the patient or others. (Repeated special incident reports)
  - c. Following notification from the quality assurance department that the patient has met a risk threshold indicating behavioral problems whose intensity or frequency poses a risk to the patient or others or is requiring restrictive interventions (e.g., seclusion, restraint) to prevent harm from occurring. (3 episodes in a 4 week block of time)
  
4. The following situations are some indicators of the need for a behavioral consultation:
  - i. Frequent/ongoing need for seclusion, restraint, and/or constant visual monitoring to prevent aggressive or self-harm behaviors that have not been resolved through rapid stabilization or intensive treatment efforts.
  - j. Need for frequent PRN medication administrations to prevent aggressive or self-harm behaviors that have not been resolved through rapid stabilization or intensive treatment efforts.
  - k. Injuries to self or others resulting from an individual's behaviors that have not been resolved through rapid stabilization or intensive treatment efforts.
  - l. Presence of behaviors which are interfering with the individual's recovery or community reintegration.
  - m. Deficits in pro-social or adaptive behaviors which are interfering with the individual's ability to benefit from treatment and make progress on life or treatment goals.
  - n. Ongoing non-adherence to clinically indicated medication.
  - o. Absence of meaningful engagement in treatment.
  - p. Problem behaviors related to the presence of dementia, traumatic brain injury or other cognitive / developmental disorders.