

## **Accessing the Developmental Disabilities Program's Behavior Consultation Team**

### **What is the Behavior Consultation Team?**

The Behavior Consultation Team (BCT) provides telephone consultation, programming assistance, and/or face-to-face assessment of individuals who engage in challenging behaviors in order to make recommendations regarding behavioral supports and crisis prevention. Behavior Consultation Specialists serve as consultants to families, group home staff, and work/day services staff. Most of the team's activity is spent providing outreach services to individuals across their residential and day program/work settings. Behavior Consultation Specialists will provide assessments and behavioral programming in order to address behaviors that may interfere with community living. The team offers staff and family behavioral skills training, individual skills training (e.g., coping skills, emotion regulation skills), and on-site coaching in order to reduce the acuity of challenging behaviors.

The intervention model developed by the Institute for Applied Behavior Analysis (IABA) provides the framework for the services of the Behavior Consultation Team. This nonaversive treatment model leads to the development of multi-component intervention plans that include both proactive and reactive strategies based on a comprehensive functional behavior assessment of the individual's challenging behavior. The proactive strategies include:

- Ecological interventions (creating a better fit between the person and their environment),
- Positive programming (skill building interventions that will lead to the development of general skills, functionally equivalent skills, functionally related skills, and coping skills), and,
- Focused intervention strategies (e.g., differential schedules of reinforcement, stimulus control, stimulus association) that aim to produce rapid behavior change while the slower acting ecological and positive programming interventions take effect.
- Reactive strategies designed to avert potential behavior incidents or to manage an incident in ways that minimize injuries to the person and/or others or serious property damage.

The Behavior Consultation Team will also conduct Functional Behavior Assessments and/or develop Behavior Support Plans for individuals when the provider agency/family does not have the resources to do so. Because of time requirements, the comprehensive approach to assessment emphasized by the IABA may not be appropriate in all cases. It is suggested, however, that if any of the following criteria are satisfied, then a comprehensive IABA assessment should be considered and may be justified:

- The person's challenging behavior persists despite consistently implemented support plans that have been based on less comprehensive and less formal methods of assessment.
- The person's behavior places the person or others at risk of harm or injury.
- Intrusive or restrictive procedures are being considered.

After a Behavior Support Plan has been designed, the Behavior Consultation Specialist and/or Behavior Intervention Specialist will provide structured and informal training in program implementation. This includes modeling of intervention strategies and providing support and advice relating to the program. This outreach support will be provided across shifts, days, and support providers. As the person's behavior improves and staff are becoming more proficient in carrying out the program, direct time from the team will be reduced.

**Who should be referred:**

In general, a person is referred when that person:

- a) Is at risk of losing their provider agency, home, or job due to behavioral concerns (e.g., self-injurious behavior, physical aggression, property damage),
- b) Has exhibited a significant deterioration in functioning over the past year,
- c) Has been hospitalized for psychiatric/behavioral reasons;
- d) Has exhibited behavior that resulted in contact with law enforcement;
- e) Has been determined by their planning team and/or BCT to need referral in order to prevent behaviors from reaching the level of a – e above.
- f) Referrals may also be made by support teams needing assistance in evaluating behaviors and in designing programs to prevent challenging behaviors from escalating to crisis level.

**Roles and Responsibilities:**

To avoid difficult situations that may arise during a BCT consultation, it is important to (a) establish a clear statement of the problem prior to the consultation, (b) clearly delineate responsibilities of all parties involved, and (c) include all results/findings in the individual's plan of care. In establishing roles and responsibilities, it is important that the BCT work collaboratively with the support team members to address issues and problem solve. While the BCT may have higher levels of technical knowledge and skills, they should not be expected to singlehandedly identify and deliver the solution to a problematic situation. Nor would it be desirable for the BCT to assume the role of sole "fixer" of an agency's or support team's behavior support problems. Regular support team members, including Direct Support Professionals, have essential information about the person and his/her situation. Regular team members also have ongoing roles and responsibilities related to providing effective support, including the ability to prevent and respond to behavioral situations that may lead to a crisis. Effective and sustainable plans and procedures are best developed and implemented in the context of a collaborative team process that uses the knowledge and strengths of regular team members and the Behavior Consultation Team. Plan maintenance involves redefining roles and responsibilities between the BCT and the parties responsible for continued implementation of the plan. Plans for maintaining staff performance and training new staff should be considered as well. Continuing evaluation efforts and procedures for plan revisions are critically important. This may involve specifying a process for shifting responsibility for plan evaluation and modification to the Quality Improvement Specialist and/or support providers. BCT involvement should be faded in a planned and efficient manner; considerations for fading include the effectiveness of the Behavior Support Plan and variables related to the capacity of the support providers. Plans must also be made for potential recurrence of challenging behavior and/or mental health symptoms. It is important to anticipate and plan for future behavioral episodes.

**What to expect from the Behavior Consultation Team:**

- Telephone consultation provided as a first step in determining priority of case;
- On-site consultation provided to family, provider agencies, work/day staff, and others who provide services to the individual;
- Functional Behavior Assessment involving direct observation, clinical file reviews and interviews, review of assessments completed by the individual's team;
- Behavior Support Plan development based on comprehensive functional assessment of the individual's challenging behavior;
- Structured and informal training in program implementation including role modeling and follow-along services provided by the BCT;

- Program monitoring and support provided until family and/or agency staff are proficient in program implementation.

**What the BCT needs from the referring party:**

- Background information including past psychiatric and psychological assessments, social history, medication history, information about the challenging behavior, and other pertinent information;
- Active participation of members of the individual’s support team including family members and direct care staff; and,
- Assistance from Regional staff including observing with the BCT, conducting fidelity checks related to the Behavior Support Plan, and monitoring of individuals who are “at risk” for challenging behavior escalation in order to provide proactive, preventive intervention.

**Who should make the referral:**

- Case Managers, State staff (e.g., Quality Improvement Specialist), parents and other natural supports, legal guardians, provider agency staff, and others who believe the individual may be at risk for or is experiencing crisis level behaviors.

**Referral process:**

The Behavior Consultation Team may be contacted in one of two ways:

- **Telephone contact:** In general, telephone contact is appropriate when minimal assistance is necessary and may include recommendations such as changing the person’s environment, modifying the person’s schedule, or identifying local resources that may be helpful. Other types of telephone consultation include problem-solving and brainstorming solutions before a crisis occurs and determining risk for crisis level behaviors. Telephone contact may also be appropriate in the case of urgent response situations. The Behavior Consultation Specialist will make a determination, along with the referral source, of the appropriate disposition of the case (e.g., on-site visit).
- **Completion of the Behavior Consultation Services Referral Form:** The referral form may be completed by any referral source listed above. Upon receipt of the form, the Behavior Consultation Specialist will contact the referral source for additional information to determine level of risk and appropriate response:
  - On-site observations and feedback: Moderate assistance is required and generally will occur between one day and one week from the time of referral. The initial on-site consultation will consist primarily of observing interactions between the individual, their staff and/or family, and their peers in the day/residential settings. If interaction styles are determined to be contributing to the behavioral issue, the BCT will make recommendations for changes before continuing with a formal Functional Behavior Assessment.
  - Urgent On-Site Response: Urgent response (i.e., generally within 24 hours) is needed to protect the person and/or others from harm.
  - If more rapid response is required, appropriate local responders should be utilized, such as law enforcement and/or emergency department.

## SAMPLE FORMS

---

Sample Referral Form

Developmental Disabilities Program  
Behavior Consultation Team Services  
Referral Form

### Step 1: Referral Process

Please print out these sheets, complete them, and fax them to the Behavior Consultation Specialist in your area. You may also access services via telephone or Therap, in which case the Behavior Consultation Specialist will complete the form.

### Step 2: Individual Information

**Today's Date:** \_\_\_\_\_

**Person being referred:** \_\_\_\_\_

**DOB (mm/dd/yy):** \_\_\_\_\_ **Age:** \_\_\_\_\_

**AWACS#:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Is this person their own guardian?**     **Yes**     **No** (If no, please provide the following:

**Guardian name:** \_\_\_\_\_

**Address/phone:** \_\_\_\_\_

**Brief reason for referral & pertinent information** (You will be able to provide more information when the Behavior Consultation Specialist contacts you):

**What are the most urgent concerns at this time? (Check all that apply)**

- Physical harm towards others
- Physical harm towards self
- Emotional harm towards others
- Harm by others
- Property destruction
- Elopement/leaving without notification
- Worsening psychiatric symptoms
- Worsening/escalating behavior(s)
- Sexual offending behavior(s)
- Significant impact on caregiver/support staff
- Other (e.g., law enforcement involvement):

**Is this person currently in the hospital or other inpatient treatment facility?**     **Yes**     **No**

**What interventions have been attempted to stabilize the situation?**

**What is the desired outcome of this consultation?**

**NOTE: If this is a psychiatric, behavioral, or medical emergency contact the person's physician or call 911.**

**Step 3: Other Information**

**Referred by:** \_\_\_\_\_  
**Relationship:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
\_\_\_\_\_  
**Phone:** \_\_\_\_\_

**Type of Residential Supports:**

- \_\_\_ Supported living services
- \_\_\_ Group home
- \_\_\_ Independent living
- \_\_\_ Foster home
- \_\_\_ Family home
- \_\_\_ Respite
- \_\_\_ None
- \_\_\_ Other

**Provider agency:** \_\_\_\_\_  
**Contact person:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_

**Case Management Information:**

**Case Manager:** \_\_\_\_\_  
**Agency:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
\_\_\_\_\_  
**Phone:** \_\_\_\_\_

**Medical & Psychiatric Information:**

Level of intellectual disability: \_\_\_ Mild \_\_\_ Moderate \_\_\_ Severe \_\_\_ Profound  
Other conditions: \_\_\_ ASD \_\_\_ CP \_\_\_ TBI \_\_\_ Other related condition

**Primary Psychiatric Diagnosis:** \_\_\_\_\_

**Psychiatric Provider:** \_\_\_\_\_

**Primary Medical Diagnosis:** \_\_\_\_\_

**Medical Specialists:** \_\_\_\_\_

**Other conditions:**

\_\_\_ Seizure disorder                      Neurologist: \_\_\_\_\_  
\_\_\_ Allergies                                Type: \_\_\_\_\_  
\_\_\_ Sleep difficulties                      \_\_\_ Swallowing difficulties                      \_\_\_ Appetite change  
\_\_\_ Change in energy level                \_\_\_ Headaches                      \_\_\_ Other: \_\_\_\_\_

**Check yes or no for the following:**

- Previous psychiatric hospitalization?  YES  NO
- Previous residential treatment facility placement?  YES  NO
- Is there a Functional Behavior Assessment?  YES  NO
- Is there a Behavior Support Plan?  YES  NO
- Is the person receiving medications:  YES  NO

If yes, please list all medications including over the counter and supplements:

---



---



---



---



---



---

**BCT Contact Information**

**Supervisor:**

Connie M. Orr, M.A., NADD-DDS  
 Helena Office  
 Phone: (406)444-3072 or (406)431-0248  
 Fax: (406)444-0230  
 Hours: Mon – Fri 8:00AM – 5:00PM

**Behavior Consultation Specialists:**

Nathan Dudley, M.A.  
 Helena Office  
 Phone: (406) 444-6904 or (406)438-6966  
 Fax: (406)444-0230  
 Hours: Mon – Fri 8:00AM – 5:00PM

Cheryl Nystrom-Ryckman  
 Billings Office  
 Phone: (406)655-7696 or (406)422-8267  
 Fax: (406)652-1895  
 Hours: Mon – Fri 8:00AM – 5:00PM

**Behavior Intervention Specialists:**

Kelli Caballero, MSW  
 Missoula Office  
 Phone: (406)329-5434 or (406)560-5644  
 Fax: (406)329-5490  
 Hours: Th – Mon 2:00PM – 10:00PM

McKenzie Lyons  
 Great Falls Office  
 Phone: (406)454-6083 or (406)781-0367  
 Fax: (406)454-6082  
 Hours: Th – Mon 2:00PM – 10:00PM

**NOTE: Hours may change based upon the needs of the person and/or provider agency/family**

---

**Team Member Notifications**

- Provider agency notified and agrees to referral:  YES  NO  Date
- Case Manager notified and agrees to referral:  YES  NO  Date
- Family/guardian notified and agrees to referral:  YES  NO  Date
- QIS notified and agrees to referral:  YES  NO  Date
- Individual notified and agrees to referral:  YES  NO  Date
- Is there PSP/Support Team consensus for consultation?  YES  NO  Date
- Regional Manager notified  Date
- Case Management Supervisor notified:  Date

Other notifications: \_\_\_\_\_

## Behavior Assessment Report and Intervention Plan Template

Client Confidential

Date of Report:

Writer(s):

### Identifying Information

This section includes information such as the person's name, date of birth, and address. It should also include the name of the referring party.

### Diagnostic Information

In this section, specific diagnoses that have been used to characterize the person and his/her behavior are described, along with the sources of each diagnosis, including specific reports, their dates, and the name of the report author(s).

### Reason(s) for Referral

In this section, the presenting problem(s) is described, along with concerns that might influence the assessment process or the Intervention Plan. Questions include:

- Who is requesting the assessment?
- Why is the assessment being requested at this time?
  - Behavior escalation?
  - Concerns regarding safety?
  - Living environment/day services in jeopardy?
  - Family overwhelmed?
  - Court order?
- Are there potential problems that might influence the assessment or treatment of the individual?

### Description of Assessment Activities

In this section, the sources from which the assessment information was gathered (e.g., interviews, psychiatric reports, observation) are listed.

### Background Information

This section includes a description and history of the individual, including placement/service history, medical and psychiatric history, and programmatic history.

- A. Brief Description of the Individual.
- B. Living Arrangement and Family Information.
- C. Daytime Service Received and Day Service History.
- D. Health, Medical, and Psychiatric Status.
- E. Previous and Current Treatments.

## Functional Behavior Assessment of Challenging Behaviors

The purpose of the Functional Behavior Assessment is to identify events that control behavior; in other words, events that cause behavior to increase and/or decrease. These events may occur before the behavior (i.e., antecedents) or after the behavior (i.e., consequences).

- A. Description of Behavior and Operational Definition. Define the behavior. This definition should represent an accurate description easily understood by all who are involved with the person. This definition includes specific concrete details to ensure that everyone is able to identify an occurrence of the challenging behavior(s) in question. Defining the behavior should include thorough and clear descriptions of the following:
1. Topography. Observable and measurable components of the behavior; a description of the physical characteristics that signal to the observer that the behavior has occurred.
  2. Measurement Criteria. The purpose of this section is to describe how the behavior may be measured/counted, including:
    - a. Occurrence (Onset/Offset). The point at which the behavior has started and the point at which it has stopped (onset and offset).
    - b. Episodic Severity. How will the severity of the behavior be measured? This would include duration, degree of injury to self/others, cost of repair/replacement, etc.
  3. Course. This includes: (1) the precursors to the behavior, i.e., those things that a person typically does prior to the onset of the behavior; (2) the topographies of the behavior as they unfold or may escalate as the episode continues; (3) the other things the person may do during an episode; (4) a description of the person's emotional expressions during an episode; and (5) a description of what the person typically does after an episode is over.
  4. Strength. Various indicators such as the frequency or number of times the behavior has occurred in a specified time period; severity of behavioral episodes (e.g., each episode poses a danger of injury to self/others); and duration of an episode, i.e., how long it lasts, including average, shortest, and longest durations.
- B. History of The Problem. When conducting a Functional Behavior Assessment, it is important to gather information regarding the history of the problem. This is accomplished by asking questions such as:
- When did the problem first appear?
  - How long has it been evident?
  - Have there been ups and downs in both the occurrence and episodic severity of the behavior over the past several days/weeks/months/years?
  - Have there been recent increases or decreases in the frequency, severity, or intensity of the problem?
  - What are major contributing factors to the challenging behavior, both recently and historically?
  - Have there been any environmental, physical, or emotional changes that may have influenced the behavior?
  - Are there any recent medical problems that might contribute to the challenging behavior?
- C. Antecedent Analysis. This section involves identifying events/conditions that occur before the challenging behavior (i.e., antecedents/instigating factors), that may result in the challenging

behavior appearing, being absent, increasing, or decreasing.

1. Triggering Events. The term “triggering” denotes that challenging behavior does not occur unless specific antecedent are present. At any given time for a person with challenging behaviors, a specific triggering event, or a stimulus complex that serves as the triggering conditions, has a certain degree of influence over specific challenging behaviors. It is important to note that any particular challenging behavior such as physical aggression may be under the influence of more than a single triggering stimulus event. Examples of triggering events include:
  - The presence of a specific person,
  - An argument with a peer,
  - A tone of voice,
  - Being requested to do something,
  - Staff changes,
  - Unpredictable changes in routines,
  - Excessive leisure time,
  - Headache, pain, ear infection, etc. that cause discomfort.
  
2. Setting Events. Setting events are stimulus conditions that, when present at the time of occurrence of a triggering event, increase the likelihood that the challenging behavior will occur following a triggering event. In some instances, an antecedent event (e.g., teasing by a peer) is not sufficient in isolation to produce a specific challenging behavior
  - In what settings is the behavior more or less likely to occur?
  - With whom is it more or less likely to occur?
  - What events, activities, interactional styles, etc. increase or decrease the likelihood of the behavior?
  - Are there internal and/or external conditions that increase or decrease the likelihood of the behavior (e.g., noise, smells, lighting, frequent relocations, limited environmental sensory stimulation, manic mood state, flights of ideas, visual/auditory/tactile hallucination, anxiety, fear, irritability, etc.)?
  
3. Vulnerability Influences. Vulnerability influences refer to those (a) personal features of a psychological (e.g., anger management, communication, or coping skills deficits) and biomedical (e.g., sensory, neurological, or biochemical impairments or dysfunctions) nature in addition to (b) those features of the physical, social, and program environments (e.g., limited opportunity for sensory or social stimulation, restrictions in the type and frequency of structured program activities) that place the person at increased risk for challenging behaviors. Examples include:
  - Traumatic experiences,
  - Social environments that provide infrequent positive feedback,
  - Lack of ability to problem solve,
  - Limited anger or anxiety management skills,
  - Limited or nonexistent verbal communication skills,
  - Low frustration tolerance,
  - Any medical condition that, on a cyclic basis, produces psychological distress (e.g., pain, irritability, fatigue) that could place a person at increased risk for the

occurrence of challenging behaviors.

- Fluctuating intensity of mood states, energy loss, and physical fatigue associated with sleep disturbances, and aberrant activity levels all increase the likelihood of aversive states of psychological distress and increase the risk of challenging behaviors.

D. Consequence Analysis.

- What was done the last time this behavior occurred and how did the person respond?
- Describe *planned reactions* that have been guided by a formal Behavior Support Plan, IEP, etc. and the effects of these reactions (e.g., escalated/de-escalated the situation, resolved/improved the situation, etc.).
- Describe any *unplanned reactions* that are not included in a BSP, such as ignoring, walking away, giving in, threatening, giving attention, touching, restrictions, etc. along with a description of the effect of unplanned reactions.
- What do people usually do when the behavior occurs?
- What methods have been used in the past and what was the effect?
- Have any formal schedules of reinforcement been used?

E. Ecological Analysis. This section includes an attempt to identify those features of the person's various environments that may result in a conflict with the person's needs and characteristics that may contribute to an understanding of why the challenging behavior is being exhibited.

F. Impressions and Analysis of Meaning. This section includes the final conclusions regarding the meaning of the challenging behavior from the person's point of view, as well as from others' points of view, and possible hypotheses about the function(s) of the challenging behavior.

#### Motivational Analysis

This area is an assessment of information gathered through interviews, observation, questionnaires (e.g., Reinforcement Inventory), and other sources regarding potential activities/events that are potentially reinforcing or motivating to the individual.

#### Mediator Analysis

This section describes the abilities and commitment of the key social agents (e.g., parents, DSPs) who will be implementing and carrying out the Intervention Plan. This should be a realistic estimate of their ability to carry out the recommended strategies given the demands of time, energy, and emotions. Moreover, there should be mention of any attitudes, motivations, philosophies, etc. of the key social agents that could impede their ability to execute the Intervention Plan. This section also contains a statement of the adequacy/inadequacy of existing resources. Suggestions should be made regarding how to alleviate any problematic areas identified in this analysis.

#### Preliminary Intervention Recommendations

This section identifies the following:

- A. Short-Term Measurable Objectives for changes in Occurrence and/or Episodic Severity of the challenging behavior(s).

B. Observation and Data Collection Procedures.

C. Recommended Strategies.

1. Ecological Strategies include environmental changes designed to reduce stress to the individual and/or increase the individual's ability to function independently and/or make choices.
2. Positive Programming includes general skills development, teaching functionally equivalent skills, and coping skills/relaxation training.
3. Focused Support Strategies such as Differential Reinforcement of Other Behaviors (DRO).
4. Reactive Strategies
  - a. Facilitating Communication
  - b. Communicating the Contingency
  - c. Stimulus Change
5. Staff Development and Management Systems. Key elements that will determine the degree of success of this support plan are staff competence and a management system that assures staff consistency in providing services to the person. The following is recommended, therefore:
  - a) Procedural Protocols. Each strategy described above should be broken into teachable steps (i.e., protocol).
  - b) Three-Tiered Training. Each staff person should be required to demonstrate three levels of competence with the above procedure: Verbal Competence (can correctly describe the procedure), Role-Play Competence (can correctly show how the procedure is carried out), and In-Vivo Competence (can correctly carry out the procedure).
  - c) Periodic Service Review (PSR). The support plan should be broken into measurable "performance standards" to be met by the support team. Monthly monitoring of these standards should be carried out by the team and the results plotted on a monthly graph.