BEHAVIORAL
SCIENCE
INITIATIVE

FUNCTIONAL BEHAVIOR ASSESSMENT
&
RECOMMENDED BEHAVIORAL SUPPORT PLAN

Date of Report: April 2025
Consumer:
DOB:
UCI#:
Site of Intervention:
Admit Date:
Phone#:
Vendor Name:
Conservator:
Service Coordinator:

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PREFACE

A Functional Behavior Assessment (FBA) is a process that identifies specific target behavior(s), the purpose of the behavior, and what factors maintain the behavior that are interfering with the individual's progress and independence. The purpose of an FBA is to obtain the contingencies between the interrelation of [redacted] "behavior" and the environment. Information was collected in a variety of settings and conditions to help determine areas of potential need, appropriate goals and supports.

SECTION 1: HISTORY

DESCRIPTION OF ASSESSMENT ACTIVITIES:

This assessment is based on information obtained from the following sources:

- Interviews with: [redacted] Services staff & administration
- Direct Observations of [redacted] in the following settings:
  - Home
- Review of the following records:
  - Previous reports, including past Behavior Support Plan, Psychological assessments, IPP, and Diagnostic information.

BRIEF BACKGROUND INFORMATION:

[redacted] is a [redacted] male diagnosed with autism spectrum disorder and Gastroesophageal Reflux Disease (GERD). He is a client of [redacted] and currently resides in a community care facility, where he receives 24-hour supervision and support services. [redacted] also attends a structured behavioral day program designed to address significant behavioral and adaptive skill deficits.

Available records and staff report indicate that [redacted] presents with substantial impairments in communication, adaptive functioning, and behavioral regulation. He is considered non-verbal and does not use functional spoken language to communicate his wants, needs, or internal states. Instead, [redacted] relies primarily on gestures, pointing, and limited vocalizations. Due to these communication deficits, maladaptive behavior frequently serves as his primary means of interacting with his environment, particularly when attempting to access preferred items, escape demands, or regulate internal sensory states.

Detailed developmental history was not available at the time of this assessment; however, [redacted] current presentation is consistent with long-standing deficits associated with autism spectrum disorder, including reduced social communication, restricted behavioral repertoires, and difficulty adapting to changes in routine. His functioning suggests a high level of dependence on environmental structure and support to maintain behavioral stability.

From an adaptive functioning standpoint, [redacted] requires assistance across multiple domains of daily living, including hygiene, dressing, and task completion. While he can complete portions of these tasks independently, he requires consistent prompting, modeling, and supervision to complete them effectively and safely. His safety awareness is significantly limited, particularly in relation to environmental hazards (e.g., unsafe food consumption), necessitating continuous supervision during waking hours across all settings.

Behaviorally, [redacted] presents with a complex and interrelated pattern of maladaptive behaviors that significantly impact his ability to participate in programming. These behaviors include food-seeking and scavenging, unsafe eating practices (e.g., overstuffing and rapid consumption), self-induced vomiting and associated behaviors (including attempts to manipulate or re-consume vomit), clothing-related maladaptive behavior (e.g., excessive changing, removal, and destruction), self-injurious behavior, and physical aggression. These behaviors occur across settings and are of sufficient frequency and intensity to pose ongoing health and safety risks.

[redacted] behavioral profile appears to be strongly influenced by a combination of high motivation for food, sensory-seeking needs, and limited functional communication. Food-related stimuli appear to function as a primary source of reinforcement, while sensory input (particularly oral and tactile stimulation) contributes to the maintenance of several behaviors. Additionally, [redacted] diagnosis of GERD may serve as a physiological variable that interacts with learned behavioral patterns, particularly in relation to vomiting behavior; however, current patterns suggest a significant behavioral component.

[redacted] benefits from highly structured environments with predictable routines, consistent supervision, and frequent access to reinforcement. He demonstrates increased engagement and reduced maladaptive behavior when provided with sensory-based activities, movement opportunities (e.g., walking), and clear expectations. Conversely, increases in maladaptive behavior are observed during periods of unstructured time, limited supervision, delayed access to reinforcement, or transitions between activities.

In summary, [redacted] presents with significant communication, behavioral, and adaptive functioning deficits that require intensive, structured, and function-based intervention. His current level of functioning is best understood within the context of limited communication abilities, strong motivating operations related to food and sensory input, and a history of reinforcement for maladaptive behavior. These variables collectively contribute to the persistence of his behaviors and inform the development of appropriate behavioral supports.

SECTION 2: OBSERVATIONS AND FUNCTIONAL ANALYSIS OF TARGETED BEHAVIORS

Observations: The following is a brief discussion addressing this ecological analysis around the physical, interpersonal, and programmatic environment. Being cognizant of these environments, the assessor attempted to answer three "screening" questions during the assessment period to help determine the need/level or "intensity" of intervention:

1. Does the individual's behavior pose a danger to himself or others?
2. Are there any behaviors that pose a health or safety hazard to others and/or [redacted] himself?
3. Are there any behaviors that affect [redacted] welfare in the current environment?

[redacted] was observed by the evaluator at [redacted]. The observations were considered "natural" because the observer made no attempt to manipulate the environment.

Consumer Interview:
A consumer interview was attempted with [redacted] during the assessment process to gather information regarding his preferences, communication style, daily routines, and behavioral presentation. Due to significant communication deficits and the absence of functional spoken language, [redacted] was unable to participate in a formal question-and-answer interview format. However, the evaluator interacted directly with [redacted] across multiple naturally occurring activities and environments to observe his methods of communication, behavioral responses, and engagement patterns.

During the interaction, [redacted] primarily communicated through gestures, physical movement toward desired items, pointing, limited vocalizations, and changes in affect. [redacted] demonstrated clear interest in food-related items, movement-based activities (e.g., walking), sensory input, and access to preferred objects. He appeared more regulated and engaged when provided with frequent structure, predictable routines, and access to preferred activities.

[redacted] demonstrated difficulty tolerating delayed access to preferred items and showed signs of frustration during transitions, waiting periods, or interruption of preferred activities. At times, maladaptive behaviors appeared to increase when communication attempts were not immediately understood by staff or when environmental expectations changed unexpectedly.

Throughout the observation and interaction process, [redacted] responded positively to calm staff interactions, guided choices, frequent redirection, and immediate reinforcement for appropriate behavior. He appeared to benefit from environments with reduced downtime, high levels of engagement, and consistent staff support.

Although [redacted] was unable to verbally describe his thoughts, feelings, or behavioral experiences directly, the interview and observational process provided clinically relevant information regarding his behavioral needs, motivational variables, communication deficits, and preferred forms of interaction. Information obtained through staff interview, direct

observation, and behavioral analysis was therefore heavily relied upon to inform the development of this assessment and support plan.

Functional Analysis of Presenting Problems:

A functional analysis was conducted for the following presenting areas of concern: food-seeking and scavenging behaviors, self-induced vomiting and associated behaviors, excessive clothing removal and destruction, self-injurious behavior (SIB), physical aggression, and related maladaptive responses.

Accordingly, this analysis endeavored to identify the environmental and internal variables that control the emission and non-emission of these targeted behaviors. This analysis is organized around six specific subcategories: (1) Description of the problem and operational definition(s); (2) History of the problem; (3) Antecedent analysis; (4) Individual variables; (5) Consequence analysis; and (6) Hypothesized function. The purpose of this approach is to identify patterns across settings and conditions in order to inform the development of effective, function-based interventions.

Available records and staff report indicate that [redacted] has a long-standing history of maladaptive behaviors, particularly those related to food, sensory regulation, and communication deficits. Food-related behaviors, including overconsumption, food seeking, and unsafe eating practices, have been persistent across both residential and day program settings. Similarly, sensory-seeking behaviors, including repetitive and ritualized responding, have been observed throughout his developmental history.

Self-injurious behavior and aggression have been reported at varying levels over time, with increases often associated with changes in environment, routine, or access to preferred stimuli. The pattern of vomiting behavior appears to have developed as part of a broader behavioral repertoire and is currently maintained by both sensory and social variables. Overall, [redacted] behavioral history reflects a pattern of behaviors that have been intermittently reinforced across time and settings, contributing to their persistence and generalization.

Operational Definitions:

- **Food Seeking / Scavenging:** Operationally defined as any instance in which [redacted] attempts to obtain, access, or consume food outside of structured program expectations. This includes but is not limited to: taking food from others, reaching for or grabbing food without permission, attempting to access restricted areas (e.g., kitchen, staff areas, vehicles), retrieving food from trash receptacles, or attempting to consume inedible or unsafe food items.

- *Exclude:* Eating food provided during scheduled meals or snacks or appropriately requesting and receiving food.
- ***Episode criteria**:* An episode begins when [redacted] initiates any attempt to access non-permitted food and ends after 2 consecutive minutes with no further attempts.
  - **Baseline**: Current data indicate that [redacted] engages in food-seeking and scavenging behaviors at a high and clinically significant rate across environments. Available data suggest that [redacted] engages in components of this response class (e.g., food stealing, eating from trash, unsafe food consumption) at 1.8 per day**,** with higher frequency observed in less structured or lower supervision conditions.
  - **Data collection method**: Frequency

- **Self-induced Vomiting**: Operationally defined as, any instance in which [redacted] engages in behavior that results in vomiting, including observable gagging, retching, or placing fingers or objects in his mouth for the apparent purpose of inducing vomiting.
  - ***Exclude****:* Vomiting that is clearly determined to be involuntary and medically related without behavioral indicators (to be determined by clinical team)
  - ***Episode criteria:*** An episode begins at the first observable precursor (e.g., gagging, retching, hand-to-mouth behavior) and ends after 5 consecutive minutes with no further vomiting-related behavior.
    - **Baseline**: Current data and staff report indicate that [redacted] engages in self-induced vomiting behavior at a high and clinically significant rate across the day. Episodes are most frequently observed following food or liquid consumption, during transitions between activities, and when access to preferred food items is denied or delayed. These episodes are often followed by additional maladaptive behaviors, including attempts to manipulate, smear, or re-consume vomit, which further increase health and safety risks. This behavior requires immediate and consistent staff intervention due to concerns related to sanitation, potential medical complications, and disruption to the program environment.
    - **Data collection method**: Frequency
- **Physical Aggression**: Operationally defined as any instance in which [redacted] engages in behavior directed toward another person that has the potential to cause physical harm. This includes but is not limited to: hitting with an open or closed hand, kicking, scratching, grabbing, pulling hair, biting others, or spitting at or toward another individual. Attempts or gestures to strike within proximity (approximately 12 inches) of another person are also included.
  - ***Exclude:*** Accidental contact (e.g., bumping into others while walking), staff-guided physical prompting, or incidental touch that is not forceful or directed with intent to harm.
  - ***Episode criteria:*** An episode begins at the first occurrence of any defined aggressive behavior and ends after 1 consecutive minute with no further physical aggression.

    - **Baseline**: Current data indicate that [redacted] engages in physical aggression at a moderate but clinically significant rate across settings. Specifically, [redacted] engages in aggressive behaviors (e.g., hitting, scratching, grabbing, or spitting toward others) at an average rate of approximately 5.09 instances per week. These behaviors are most likely to occur during situations involving increased demands, transitions, or unfamiliar environments, and typically require immediate staff intervention to ensure the safety of [redacted] and others.
    - **Data collection method**: Frequency and Intensity

- **4) Excessive Clothing Change Disruption**: Any instance in which [redacted] engages in inappropriate manipulation of clothing outside of expected or staff-directed contexts. This includes, but is not limited to: (a) removing clothing in non-private or non-designated situations, (b) attempting to remove clothing without staff approval, (c) changing clothing more than once within a 15-minute period without staff direction, (d) ripping, tearing, or otherwise damaging clothing, and/or (e) intentionally soiling clothing (e.g., through smearing substances such as food or vomit) for the apparent purpose of obtaining access to different clothing.
  - ***Exclude:*** Appropriate clothing changes associated with hygiene routines, toileting, bathing, or staff-directed clothing changes due to legitimate need (e.g., spills, accidents).
  - ***Episode criteria:*** An episode begins at the first instance of clothing manipulation (e.g., pulling at clothing, initiating removal, or damaging clothing) and ends after 2 consecutive minutes with no further clothing-related maladaptive behavior.
    - **Baseline**: Current data and staff report indicate that George engages in clothing-related maladaptive behavior at high rate across the day. Direct data collection reflects that clothing destruction occurs at an average rate of approximately 7 instances per site visit (approximately 4 hours per day) ; however, this likely underrepresents the full extent of the behavior, as frequent clothing removal and excessive changing are also observed but not consistently captured within current data systems. Staff report and observation indicate that [redacted] engages in clothing removal and/or attempts to change clothing multiple times throughout the day, particularly following episodes of vomiting, during periods of dysregulation, or when access to preferred clothing items is restricted. These behaviors require frequent staff redirection and supervision due to their impact on hygiene, program participation, and overall behavioral regulation.
    - **Data collection method**: Frequency and Intensity

- **Self-Injurious behavior**: Any instance in which [redacted] engages in behavior that results in or has the potential to result in physical harm to his own body. This includes but is not limited to: biting his body (e.g., hands, arms), scratching or picking at skin with sufficient force to cause redness, marks, or tissue damage, pulling hair, or striking his body against objects or with his hands.
  - ***Exclude:*** Non-injurious contact such as light touching, rubbing, or scratching that does not result in visible marks, tissue damage, or observable force.
  - ***Episode criteria:*** An episode begins at the first occurrence of any defined self-injurious behavior and ends after 1 consecutive minute with no further SIB.
    - **Baseline**: Current data indicate that [redacted] engages in self-injurious behavior at a high and clinically significant rate across settings. Specifically, [redacted] engages in behaviors such as biting, scratching, and pulling at his body at an average rate of approximately 8 instances per week**.** These behaviors are most frequently observed during situations involving delayed access to preferred items, particularly food, as well as during periods requiring waiting or limited access to reinforcement. Episodes of SIB often require immediate staff intervention to ensure safety and to prevent escalation or injury. Given the frequency and potential for physical harm, self-injurious behavior represents a significant area of concern and warrants continued intensive intervention.
    - **Data collection method**: Frequency and Intensity

IDENTIFICATION OF "ABC" Variables:

The following antecedent, setting events and MO's variables appear to serve as "triggers" of [redacted] targeted behavior (e.g., variables that occur prior to exhibiting the behavior):

- **Food Seeking / Scavenging Behavior:**
  - Setting Events/MOs
    - High motivation for food (frequent deprivation states)
    - Limited access to preferred food items
    - Probable: Sensory-seeking needs (oral stimulation)
    - Periods of low engagement or unstructured time
    - Probable: Physiological variables (hunger, GERD-related discomfort)
  - Immediate Triggers/SDs
    - Presence or visibility of food
    - Food being consumed by others
    - Access to kitchen, trash, or restricted areas
    - Staff not in immediate proximity
    - Transitions or downtime

- **Self-Induced Vomiting**
  - Setting Events/MOs
    - Sensory reinforcement associated with vomiting
    - Probable: Physiological variables (GERD)
    - High food motivation / overconsumption
    - Probable: Learned association between vomiting and reinforcement (e.g., attention, clothing access)
  - Immediate Triggers/SDs
    - Following food or liquid consumption
    - Denied or delayed access to additional food
    - Transitions between activities
    - Periods of low stimulation
- **Physical Aggression:**
  - Setting Events/MOs
    - Escalation from frustration or SIB
    - Limited communication ability
    - Low tolerance for delay or denial
  - Immediate Triggers/SDs
    - Staff-imposed demands
    - Redirection or interruption of behavior
    - Physical proximity during escalation
    - Transitions or unfamiliar environments
- **Excessive Clothing Change Disruption:**
  - Setting Events/MOs
    - Sensory regulation needs (tactile stimulation)
    - Desire for access to preferred clothing
    - Learned association between soiling clothing and obtaining replacements
    - Probable: Emotional dysregulation
  - Immediate Triggers/SDs
    - Access to clothing
    - Clothing becoming soiled (e.g., after vomiting)
    - Transitions or downtimes
    - Limited staff supervision

- **Self-Injurious Behavior**
    - Setting Events/MOs
        - Limited communication skills
        - High motivation for tangibles (especially food)
        - Sensory reinforcement
        - Probable: Low frustration tolerance
        - Probable: Emotional dysregulation
    - Immediate Triggers/SDs
        - Denied or delayed access to preferred items
        - Waiting requirements
        - Transitions
        - Communication breakdowns
        - Redirection from staff

The following individual variables were identified as factors that appear to contribute to the occurrence of [redacted] targeted behaviors:

- **Significant communication deficits**, including minimal functional expressive language, resulting in reliance on maladaptive behavior as a primary means of expressing wants, needs, and internal states.
- **Strong tangible-seeking motivation**, particularly related to food, with frequent deprivation states that increase the likelihood of food-seeking, unsafe eating behaviors, and associated maladaptive responses.
- **Sensory-seeking tendencies**, especially related to oral and tactile stimulation, which appear to maintain behaviors such as vomiting, manipulation of substances, and repetitive clothing-related behaviors.
- **Diagnosis of Gastroesophageal Reflux Disease (GERD)**, which may serve as a physiological setting event and interact with learned behavioral patterns, particularly in relation to vomiting behavior.
- **Limited delay tolerance**, resulting in difficulty waiting for preferred items or activities and increased likelihood of escalation when access is denied or delayed.
- **Low frustration tolerance**, particularly in situations involving transitions, restricted access to preferred items, or communication breakdowns.
- **History of reinforcement for maladaptive behavior**, including access to food, sensory input, or escape from demands, which has contributed to the persistence and generalization of these behaviors across settings.
- **Limited adaptive coping repertoire**, with few functional strategies available to regulate emotional or sensory states, increasing reliance on maladaptive responses.
- **Deficits in self-regulation**, including difficulty modulating arousal levels, particularly during transitions or periods of low stimulation.
- **Difficulty with transitions and changes in routine**, resulting in increased likelihood of behavioral escalation during movement between activities or environments.

- **Reduced safety awareness**, including limited understanding of environmental risks (e.g., unsafe food consumption, choking hazards), requiring continuous supervision.
- **Cognitive limitations associated with autism spectrum disorder**, including reduced flexibility, difficulty with problem-solving, and challenges generalizing learned skills across environments.
- **High dependence on environmental structure**, with increased maladaptive behavior observed during periods of unstructured time or reduced supervision.
- **Behavioral chaining across response classes**, in which one behavior (e.g., food seeking or vomiting) increases the likelihood of subsequent behaviors (e.g., clothing disruption, sensory manipulation), resulting in a compounded behavioral episode.
- **Inconsistent communication-response contingencies**, where delays or inconsistencies in staff response to communication attempts may increase reliance on more immediate and historically reinforced maladaptive behaviors.

The following variables were identified as consequences of [redacted] challenging behaviors (e.g., variables that follow the occurrence of challenging behavior):

- **Access to food or food-related stimuli**, either directly (e.g., obtaining food items) or indirectly (e.g., increased monitoring that still results in eventual access), particularly following food-seeking or mealtime-related behaviors.
- **Access to sensory stimulation**, including oral and tactile input (e.g., stimulation associated with vomiting, manipulation of substances, or repetitive behaviors), which may function as automatic reinforcement.
- **Increased staff attention**, including verbal redirection, prompting, physical proximity, and engagement, which may inadvertently reinforce behaviors, especially in the absence of functional communication.
- **Immediate staff intervention**, including blocking, redirection, or escorting, which may function as attention or alter task demands.
- **Escape or delay of demands**, including removal from tasks, postponement of transitions, or reduction in expectations following escalation.
- **Removal from current activity or environment**, particularly during episodes of escalation, which may function as both escape and access to lower-demand settings.
- **Access to preferred items or alternative activities**, sometimes provided following escalation as part of de-escalation strategies.
- **Access to replacement clothing**, particularly following episodes involving vomiting or clothing disruption, which may reinforce clothing-related maladaptive behavior.
- **Environmental reset or clean-up procedures**, including removal of stimuli, staff-led sanitation, or disruption of ongoing activities, which may function as escape from expectations or alter environmental conditions.
- **Increased supervision or staff proximity**, which may function as attention and alter the availability of reinforcement.
- **Termination or modification of task demands**, particularly during periods of escalation, which may reinforce escape-maintained behavior.

- **Inconsistent reinforcement contingencies**, where behavior may sometimes result in access to desired outcomes and other times not, strengthening persistence of maladaptive behavior through intermittent reinforcement.
- **Delayed reinforcement of appropriate behavior**, where appropriate communication or compliance may not be reinforced as quickly or consistently as maladaptive behavior, increasing the relative efficiency of problem behavior.

CLINICAL INTERPRETATION:
There are several factors that are helpful in trying to understand the meaning of [redacted] behavior. It is the opinion of the evaluator that [redacted] behavior is highly heterogeneous in presentation and may range from minor and/or innocuous in presentation to an array of incongruous behaviors. The variables that have an effect and may trigger the identified target behaviors appear to be based on both performance and skill deficits.

SECTION 3: SUMMARY AND RECOMMENDATIONS

[redacted] was referred for a Functional Behavior Assessment due to his recent transition into [redacted] Day Program and past behavioral excesses/deficits. The results of the assessment indicate that [redacted] engages in socially significant behaviors that interfere with the physical, interpersonal, and programmatic environments within [redacted] Day Program. Therefore, the following is recommended for consideration by [redacted] support team:

LONG-TERM GOAL: Self-Determination The long-term goal for [redacted] is to develop sufficient self-control over his own behavior so that he can function in the least restrictive setting possible. The goal of this plan is to equip [redacted] with the necessary skills to meet his needs while eliminating behaviors that tend to stigmatize and isolate him, thereby promoting greater independence and participation. Additionally, efforts will be made to transfer the control of [redacted] behavior from external mediators to internally generated or intrinsic motivators.

BEHAVIOR PLAN: The following is a behavior plan(s) are subject to change after the onset of intervention, and more information is obtained about [REDACTED] current level of functioning.

Section: ***Operational Definitions***

- **Food Seeking / Scavenging:** Operationally defined as any instance in which [REDACTED] attempts to obtain, access, or consume food outside of structured program expectations. This includes but is not limited to: taking food from others, reaching for or grabbing food without permission, attempting to access restricted areas (e.g., kitchen, staff areas, vehicles), retrieving food from trash receptacles, or attempting to consume inedible or unsafe food items.
    - ***Exclude:*** Eating food provided during scheduled meals or snacks or appropriately requesting and receiving food.
    - ***Episode criteria:*** An episode begins when [REDACTED] initiates any attempt to access non-permitted food and ends after 2 consecutive minutes with no further attempts.
        - **Baseline**: Current data indicate that [REDACTED] engages in food-seeking and scavenging behaviors at a high and clinically significant rate across environments. Available data suggest that [REDACTED] engages in components of this response class (e.g., food stealing, eating from trash, unsafe food consumption) at 1.8 per day**,** with higher frequency observed in less structured or lower supervision conditions.
        - **Data collection method**: Frequency
- **Self-induced Vomiting**: Operationally defined as, any instance in which [REDACTED] engages in behavior that results in vomiting, including observable gagging, retching, or placing fingers or objects in his mouth for the apparent purpose of inducing vomiting.
    - ***Exclude:*** Vomiting that is clearly determined to be involuntary and medically related without behavioral indicators (to be determined by clinical team)
    - ***Episode criteria:*** An episode begins at the first observable precursor (e.g., gagging, retching, hand-to-mouth behavior) and ends after 5 consecutive minutes with no further vomiting-related behavior.
        - **Baseline**: Current data and staff report indicate that [REDACTED] engages in self-induced vomiting behavior at a high and clinically significant rate across the day. Episodes are most frequently observed following food or liquid consumption, during transitions between activities, and when access to preferred food items is denied or delayed. These episodes are often followed by additional maladaptive behaviors, including attempts to manipulate, smear, or re-consume vomit, which further increase health and safety risks. This behavior requires immediate and consistent staff intervention due to concerns related to sanitation, potential medical complications, and disruption to the program environment.
        - **Data collection method**: Frequency

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- **Physical Aggression**: Operationally defined as any instance in which [redacted] engages in behavior directed toward another person that has the potential to cause physical harm. This includes but is not limited to: hitting with an open or closed hand, kicking, scratching, grabbing, pulling hair, biting others, or spitting at or toward another individual. Attempts or gestures to strike within proximity (approximately 12 inches) of another person are also included.
    - ***Exclude:*** Accidental contact (e.g., bumping into others while walking), staff-guided physical prompting, or incidental touch that is not forceful or directed with intent to harm.
    - ***Episode criteria:*** An episode begins at the first occurrence of any defined aggressive behavior and ends after 1 consecutive minute with no further physical aggression.
        - **Baseline**: Current data indicate that [redacted] engages in physical aggression at a moderate but clinically significant rate across settings. Specifically, [redacted] engages in aggressive behaviors (e.g., hitting, scratching, grabbing, or spitting toward others) at an average rate of approximately 5.09 instances per week. These behaviors are most likely to occur during situations involving increased demands, transitions, or unfamiliar environments, and typically require immediate staff intervention to ensure the safety of [redacted] and others.
        - **Data collection method**: Frequency and Intensity
- **Excessive Clothing Change Disruption**: Any instance in which [redacted] engages in inappropriate manipulation of clothing outside of expected or staff-directed contexts. This includes, but is not limited to: (a) removing clothing in non-private or non-designated situations, (b) attempting to remove clothing without staff approval, (c) changing clothing more than once within a 15-minute period without staff direction, (d) ripping, tearing, or otherwise damaging clothing, and/or (e) intentionally soiling clothing (e.g., through smearing substances such as food or vomit) for the apparent purpose of obtaining access to different clothing.
    - ***Exclude:*** Appropriate clothing changes associated with hygiene routines, toileting, bathing, or staff-directed clothing changes due to legitimate need (e.g., spills, accidents).
    - ***Episode criteria:*** An episode begins at the first instance of clothing manipulation (e.g., pulling at clothing, initiating removal, or damaging clothing) and ends after 2 consecutive minutes with no further clothing-related maladaptive behavior.
        - **Baseline**: Current data and staff report indicate that George engages in clothing-related maladaptive behavior at high rate across the day. Direct data collection reflects that clothing destruction occurs at an average rate of approximately 7 instances per site visit (approximately 4 hours per day) ; however, this likely underrepresents the full extent

of the behavior, as frequent clothing removal and excessive changing are also observed but not consistently captured within current data systems. Staff report and observation indicate that [redacted] engages in clothing removal and/or attempts to change clothing multiple times throughout the day, particularly following episodes of vomiting, during periods of dysregulation, or when access to preferred clothing items is restricted. These behaviors require frequent staff redirection and supervision due to their impact on hygiene, program participation, and overall behavioral regulation.

- **Data collection method**: Frequency and Intensity

- **Self-Injurious behavior**: Any instance in which [redacted] engages in behavior that results in or has the potential to result in physical harm to his own body. This includes but is not limited to: biting his body (e.g., hands, arms), scratching or picking at skin with sufficient force to cause redness, marks, or tissue damage, pulling hair, or striking his body against objects or with his hands.
    - ***Exclude:*** Non-injurious contact such as light touching, rubbing, or scratching that does not result in visible marks, tissue damage, or observable force.
    - ***Episode criteria:*** An episode begins at the first occurrence of any defined self-injurious behavior and ends after 1 consecutive minute with no further SIB.
        - **Baseline**: Current data indicate that [redacted] engages in self-injurious behavior at a high and clinically significant rate across settings. Specifically, [redacted] engages in behaviors such as biting, scratching, and pulling at his body at an average rate of approximately 8 instances per week**.** These behaviors are most frequently observed during situations involving delayed access to preferred items, particularly food, as well as during periods requiring waiting or limited access to reinforcement. Episodes of SIB often require immediate staff intervention to ensure safety and to prevent escalation or injury. Given the frequency and potential for physical harm, self-injurious behavior represents a significant area of concern and warrants continued intensive intervention.
        - **Data collection method**: Frequency and Intensity

Section 2: ***Current Antecedents***

- **Food Seeking / Scavenging Behavior:**
    - Setting Events/MOs
        - High motivation for food (frequent deprivation states)
        - Limited access to preferred food items
        - Probable: Sensory-seeking needs (oral stimulation)
        - Periods of low engagement or unstructured time
        - Probable: Physiological variables (hunger, GERD-related discomfort)
    - Immediate Triggers/SDs
        - Presence or visibility of food

    - Food being consumed by others
    - Access to kitchen, trash, or restricted areas
    - Staff not in immediate proximity
    - Transitions or downtime
- **Self-Induced Vomiting**
  - Setting Events/MOs
    - Sensory reinforcement associated with vomiting
    - Probable: Physiological variables (GERD)
    - High food motivation / overconsumption
    - Probable: Learned association between vomiting and reinforcement (e.g., attention, clothing access)
  - Immediate Triggers/SDs
    - Following food or liquid consumption
    - Denied or delayed access to additional food
    - Transitions between activities
    - Periods of low stimulation
- **Physical Aggression:**
  - Setting Events/MOs
    - Escalation from frustration or SIB
    - Limited communication ability
    - Low tolerance for delay or denial
  - Immediate Triggers/SDs
    - Staff-imposed demands
    - Redirection or interruption of behavior
    - Physical proximity during escalation
    - Transitions or unfamiliar environments
- **Excessive Clothing Change Disruption:**
  - Setting Events/MOs
    - Sensory regulation needs (tactile stimulation)
    - Desire for access to preferred clothing
    - Learned association between soiling clothing and obtaining replacements
    - Probable: Emotional dysregulation
  - Immediate Triggers/SDs
    - Access to clothing
    - Clothing becoming soiled (e.g., after vomiting)
    - Transitions or downtimes
    - Limited staff supervision
- **Self-Injurious Behavior**
  - Setting Events/MOs
    - Limited communication skills
    - High motivation for tangibles (especially food)
    - Sensory reinforcement

        - Probable: Low frustration tolerance
        - Probable: Emotional dysregulation
    - Immediate Triggers/SDs
        - Denied or delayed access to preferred items
        - Waiting requirements
        - Transitions
        - Communication breakdowns
        - Redirection from staff

Section 3: Individual Variables:

- **Significant communication deficits**, including minimal functional expressive language, resulting in reliance on maladaptive behavior as a primary means of expressing wants, needs, and internal states.
- **Strong tangible-seeking motivation**, particularly related to food, with frequent deprivation states that increase the likelihood of food-seeking, unsafe eating behaviors, and associated maladaptive responses.
- **Sensory-seeking tendencies**, especially related to oral and tactile stimulation, which appear to maintain behaviors such as vomiting, manipulation of substances, and repetitive clothing-related behaviors.
- **Diagnosis of Gastroesophageal Reflux Disease (GERD)**, which may serve as a physiological setting event and interact with learned behavioral patterns, particularly in relation to vomiting behavior.
- **Limited delay tolerance**, resulting in difficulty waiting for preferred items or activities and increased likelihood of escalation when access is denied or delayed.
- **Low frustration tolerance**, particularly in situations involving transitions, restricted access to preferred items, or communication breakdowns.
- **History of reinforcement for maladaptive behavior**, including access to food, sensory input, or escape from demands, which has contributed to the persistence and generalization of these behaviors across settings.
- **Limited adaptive coping repertoire**, with few functional strategies available to regulate emotional or sensory states, increasing reliance on maladaptive responses.
- **Deficits in self-regulation**, including difficulty modulating arousal levels, particularly during transitions or periods of low stimulation.
- **Difficulty with transitions and changes in routine**, resulting in increased likelihood of behavioral escalation during movement between activities or environments.
- **Reduced safety awareness**, including limited understanding of environmental risks (e.g., unsafe food consumption, choking hazards), requiring continuous supervision.
- **Cognitive limitations associated with autism spectrum disorder**, including reduced flexibility, difficulty with problem-solving, and challenges generalizing learned skills across environments.
- **High dependence on environmental structure**, with increased maladaptive behavior observed during periods of unstructured time or reduced supervision.

- **Behavioral chaining across response classes**, in which one behavior (e.g., food seeking or vomiting) increases the likelihood of subsequent behaviors (e.g., clothing disruption, sensory manipulation), resulting in a compounded behavioral episode.
- **Inconsistent communication-response contingencies**, where delays or inconsistencies in staff response to communication attempts may increase reliance on more immediate and historically reinforced maladaptive behaviors.

Section 4: Current Consequences:

- **Access to food or food-related stimuli**, either directly (e.g., obtaining food items) or indirectly (e.g., increased monitoring that still results in eventual access), particularly following food-seeking or mealtime-related behaviors.
- **Access to sensory stimulation**, including oral and tactile input (e.g., stimulation associated with vomiting, manipulation of substances, or repetitive behaviors), which may function as automatic reinforcement.
- **Increased staff attention**, including verbal redirection, prompting, physical proximity, and engagement, which may inadvertently reinforce behaviors, especially in the absence of functional communication.
- **Immediate staff intervention**, including blocking, redirection, or escorting, which may function as attention or alter task demands.
- **Escape or delay of demands**, including removal from tasks, postponement of transitions, or reduction in expectations following escalation.
- **Removal from current activity or environment**, particularly during episodes of escalation, which may function as both escape and access to lower-demand settings.
- **Access to preferred items or alternative activities**, sometimes provided following escalation as part of de-escalation strategies.
- **Access to replacement clothing**, particularly following episodes involving vomiting or clothing disruption, which may reinforce clothing-related maladaptive behavior.
- **Environmental reset or clean-up procedures**, including removal of stimuli, staff-led sanitation, or disruption of ongoing activities, which may function as escape from expectations or alter environmental conditions.
- **Increased supervision or staff proximity**, which may function as attention and alter the availability of reinforcement.
- **Termination or modification of task demands**, particularly during periods of escalation, which may reinforce escape-maintained behavior.
- **Inconsistent reinforcement contingencies**, where behavior may sometimes result in access to desired outcomes and other times not, strengthening persistence of maladaptive behavior through intermittent reinforcement.
- **Delayed reinforcement of appropriate behavior**, where appropriate communication or compliance may not be reinforced as quickly or consistently as maladaptive behavior, increasing the relative efficiency of problem behavior.

Section 5: Hypothesized Function of Behavior:

- **Food Seeking / Scavenging Behavior:**
  - Primary: Access to Tangibles (Food)
  - Secondary: Automatic Reinforcement (Oral/Sensory)
- **Self-Induced Vomiting Behavior:**
  - Primary: Automatic Reinforcement (Sensory)
  - Secondary: Access to Tangibles (Food/Clothing)
  - Tertiary: Escape
- **Excessive Clothing Change Disruption:**
  - Primary: Access to Tangibles (Clothing)
  - Secondary: Automatic Reinforcement (Sensory)
  - Tertiary: Escape
- **Self-Injurious Behavior (SIB):**
  - Primary: Automatic Reinforcement
  - Secondary: Access to Tangibles
  - Tertiary: Escape
- **Physical Aggression:**
  - Primary: Escape
  - Secondary: Access to Tangibles (Food)
  - Tertiary: Attention

Section 6: Functionally Equivalent Replacement Behavior*:*

- **Food Seeking / Scavenging Behavior:**
  - **FERB:** Appropriately requesting access to food using functional communication (e.g., gesture, sign, or visual cue such as "more" or pointing) and waiting for delivery of food within a structured schedule.
- **Self-Induced Vomiting Behavior:**
  - **FERB:** Requesting assistance, a break, or access to preferred items (e.g., food, sensory input) using functional communication, and engaging in alternative sensory or regulatory activities (e.g., walking, sensory items).
- **Clothing-Related Maladaptive Behavior:**
  - **FERB:** Requesting a clothing change appropriately using functional communication and maintaining appropriate clothing wear between scheduled or staff-approved clothing changes.
- **Self-Injurious Behavior (SIB):**
  - **FERB:** Requesting access to preferred items, assistance, or a break using functional communication, and engaging in alternative self-regulation strategies (e.g., sensory items, movement activities).

- **Physical Aggression:**
    - **FERB:** Using functional communication to request a break, assistance, or access to preferred items, and engaging in appropriate distancing or disengagement behaviors when experiencing frustration.

Section 7: Antecedent Changes:

- **Supervision & Safety Considerations:** Due to the severity, frequency, and intensity of the behaviors exhibited, [redacted] requires continuous 1:1 staffing throughout his day program visit to ensure safety, provide immediate support, and allow for proactive intervention. This level of supervision is especially critical in community settings, where environmental variables and safety risks are less predictable.
- Continue use of site wide behavioral supports: Point System; incentives, behavioral contracts, terms & concepts, etc.
    - Allow opportunities for increased autonomy. [redacted] should be permitted to choose from a "pre-approved" list of reinforcers.
    - Mix up/change reinforcer menu often to avoid potential satiation when appropriate
    - maintain 1:1 supervision.
- "Catching:" Deliver high quality (behavior specific) attention intermittently throughout the day; do not wait to deliver such attention contingent on precursor or target behavior objectives.
- **Structured Daily Programming:** [redacted] requires a highly structured and predictable daily schedule. Unstructured time should be minimized (no more than 2-3 minutes without engagement). All activities should have a clear beginning and end, and transitions should be brief and supported.
- **Food Access Control System:** Given the strong motivating operation for food:
    - All non-program food should be removed from visible and accessible areas
    - Access to kitchens, trash, and staff food areas should be restricted or supervised
    - Staff should ensure food is not visible in personal belongings or vehicles
    - [redacted] should be provided with frequent, scheduled access to small portions of food to reduce deprivation states
- **Mealtime Structure & Pacing During meals:**
    - Staff should provide continuous supervision and prompting
    - Use pacing strategies (e.g., one bite at a time, prompts to chew/swallow)
    - Limit access to large quantities of food at once
    - Reinforce appropriate eating behavior immediately
- Continue utilizing the "4 PPI's:"
    - **Introduce Positively-** Phrasing, presenting, communicating transitions that highlight positive outcomes that benefit the program participant.
    - **Clarify Expectations-** Review (using as much QBI's as possible) & clarify what needs to be achieved for success.

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- **Model, Coach & Teach-** Model by physically demonstrating appropriate and expected behavior at all times. Teach by showing and explaining the skill. Coach by training, practicing and praising the appropriate behaviors you identify (Role Plays).
- **Celebrate Frequently-** Praise by acknowledging a positive behavior or act and observe or honor (point contract) a special event or social gathering.

- **Functional Communication Training (FCT) & Proactive Use:**
  - Staff should prompt functional communication before the occurrence of problem behavior, including:
    - Requesting "more," "help," or "all done"
    - Using gestures, signs, or visual supports

    Communication should be reinforced immediately and consistently
- **Sensory Regulation Supports:** [redacted] should have access to frequent sensory input throughout the day, including:
  - Scheduled sensory activities every 10-15 minutes
  - Access to appropriate sensory items (e.g., tactile objects)
  - Movement-based activities (e.g., walking) incorporated throughout the day
- **Movement & Walking Schedule:**
  - Walking should be incorporated as a planned and proactive intervention**,** with a minimum of 3-5 scheduled walks per day, and additional access provided during early signs of escalation.
- **Clothing Access Management:** To reduce clothing-related maladaptive behavior:
  - Extra clothing should be stored in staff-controlled areas.
  - Clothing changes should occur on a structured schedule or upon appropriate request.
  - Reinforcement for excessive changing should be thinned.
- **Transition Supports:** Given difficulty with transitions:
  - Provide pre-transition warnings (gestural or visual)
  - Use First/Then supports
  - Keep transitions brief and structured
  - Reinforce successful transitions
- **Environmental Arrangement:** The environment should be arranged to:
  - Minimize access to reinforcing stimuli associated with targeted behavior.
  - Increase access to appropriate alternative(s).
  - Reduce exposure to triggers (e.g., visible food, clutter, unstructured areas).
- **High Rate of Noncontingent Reinforcement (NCR):**
  - Provide frequent, noncontingent access to reinforcement (e.g., small food items, attention, sensory input) throughout the day to reduce motivation for maladaptive behavior.
- **Staff Consistency & Implementation Fidelity:**
  - All staff must implement interventions consistently across settings**.** Inconsistent responses to behavior (e.g., occasionally allowing access to food following problem behavior) may strengthen maladaptive responding.

Section 8: Reactive Strategies:

- **General response to behavior(s):** Remain calm while interacting with [redacted] during an "episode" (i.e., utilize appropriate tone, volume and cadence; utilize a soft and neutral tone and minimize communication to brief and specific comments when he is upset.
- **Chain interruption & redirection:** Staff should identify and establish strategies that have historically de-escalated George's behavior in the past. ([redacted] targeted behaviors have been defined into two levels as described above. Staff will be trained to take data based on the behavioral definitions; consequently, the chain interruption & redirection procedure will be created over time based on the analysis of [redacted] data).
- **Functional Communication Prompting:** During early stages of escalation, staff should prompt and reinforce functionally equivalent communication responses (FCRs) such as requesting "more," "help," "all done," or a break. Appropriate communication attempts should be reinforced immediately**.**
- **Set limits:** Minimize interactions/verbalizations during an episode; Catch [redacted] being appropriate/making good choices by intermittently delivering attention/guided choices.
- **Provide guided choices.** Choice can provide [redacted] with an opportunity to have "control" over his environment.
    - Examples Include:
        - Choice of activity and steps within activity
        - Choice of assigned task
        - Choice of task sequence
        - Choice of reinforcement(s) (i.e., as described above in antecedent changes)
- **Planned Ignoring (when appropriate):** For behaviors maintained by attention (e.g., non-dangerous vocalizations), staff may use planned ignoring while continuing to monitor safety and reinforce appropriate behavior.
- **Food Seeking / Scavenging Behavior:**
    - Block access to unsafe or non-permitted food
    - Redirect to scheduled food access or appropriate activity
    - Prompt functional communication
    - Avoid providing food immediately following maladaptive behavior unless part of a planned intervention
- **Self-Induced Vomiting Behavior:**
    - Maintain a neutral response (do not provide excessive attention)
    - Redirect George to a designated area if necessary
    - Prevent access to vomit when safe to do so
    - Follow sanitation procedures
    - Avoid providing preferred items immediately following the behavior

- **Clothing-Related Maladaptive Behavior:**
  - Block inappropriate removal or destruction of clothing when safe
  - Redirect to appropriate behavior
  - Provide access to clothing changes only when appropriate and scheduled
  - Reinforce appropriate clothing use and compliance
- **Self-Injurious Behavior (SIB):**
  - Ensure immediate safety of [redacted]
  - Block behavior if necessary and appropriate
  - Reduce environmental demands
  - Provide alternative sensory input or calming activity
  - Reinforce calm behavior as soon as it occurs
- **Physical Aggression:**
  - Maintain safe distance and ensure safety of all individuals
  - Utilize CPI-approved de-escalation strategies
  - Reduce verbal interaction and environmental demands
  - Remove audience and unnecessary stimuli when possible
  - Implement physical intervention only as a last resort and in accordance with training

Section 9: Skills to Teach

- **Staff:**
  - **Functional Communication Training (FCT) Implementation:** Staff will be trained to identify opportunities to prompt and reinforce functional communication (e.g., “more,” “help,” “all done”) prior to the occurrence of maladaptive behavior.
  - **Reinforcement Delivery:** Staff will be trained to deliver immediate, consistent, and behavior-specific reinforcement for appropriate behavior, including communication attempts, waiting, and task engagement.
  - **Prompting Hierarchy:** Staff will be trained to use appropriate prompting strategies (e.g., gestural, model, physical prompting) and to systematically fade prompts to promote independence.
  - **Antecedent Strategy Implementation:** Staff will be trained to implement proactive supports, including:
    - Structured scheduling
    - Food access control
    - Sensory supports
    - Transition supports
  - **Behavior Prevention Strategies:** Staff will be trained to recognize early signs of escalation and implement preventative strategies (e.g., redirection, offering choices, increasing reinforcement).

  - **Data Collection Procedures:** Staff will be trained to accurately collect data on targeted behaviors, including frequency and intensity, and to ensure consistency across settings.
  - **Guided Choice & Environmental Control:** Staff will be trained to provide structured choices to increase compliance and reduce escape-maintained behavior.
  - **Crisis Prevention and De-escalation (CPI):** Staff will be trained in CPI strategies, including:
    - Rational detachment
    - Verbal de-escalation
    - Safe and appropriate intervention procedures
- **[REDACTED]:**
  - **Functional Communication Skills:** [REDACTED] will be taught to request needs using gestures, signs, or visual supports, including:
    - "More" (requesting items, especially food)
    - "All done" (termination of activity)
    - "Help" (assistance)
    - "Wait" (tolerance for delay)
  - **Waiting Tolerance:** [REDACTED] will be taught to tolerate short delays in reinforcement, gradually increasing duration over time with reinforcement.
  - **Appropriate Eating Skills:** [REDACTED] will be reinforced when:
    - Taking one bite at a time
    - Chewing and swallowing before taking another bite
    - Remaining in designated eating areas
  - **Transition Skills:** [REDACTED] will be taught to transition between activities with support, including following visual or gestural cues and tolerating changes in routine.
  - **Alternative Sensory Behaviors:** [REDACTED] will be taught to engage in appropriate sensory activities (e.g., using sensory items, walking) as an alternative to maladaptive sensory-seeking behavior.
  - **Self-Regulation Skills:** [REDACTED] will be taught to engage in simple, functional calming strategies (e.g., movement-based activities, accessing preferred items) with staff support.
  - **Compliance with Daily Structure:** [REDACTED] will be taught to follow structured routines and engage in scheduled activities with reinforcement.
  - **Appropriate Clothing Behavior:** [REDACTED] will be taught to maintain appropriate clothing wear and to request clothing changes appropriately when needed

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Reinforcement Procedures

The following reinforcement procedures are designed to increase appropriate behavior, strengthen functional communication, reduce motivation for maladaptive behavior, and promote the acquisition of adaptive replacement skills. Reinforcement should be delivered consistently across staff, settings, and activities to ensure treatment integrity and behavioral stability.

Differential Reinforcement Procedures

Staff will utilize Differential Reinforcement procedures throughout the day to strengthen appropriate and functionally equivalent behaviors while reducing reinforcement for maladaptive responses.

Procedures may include:

- Differential Reinforcement of Alternative Behavior (DRA)
- Differential Reinforcement of Incompatible Behavior (DRI)
- Differential Reinforcement of Other Behavior (DRO), when clinically appropriate

Primary emphasis should be placed on reinforcing:

- Functional communication
- Appropriate requesting
- Waiting tolerance
- Task engagement
- Appropriate transitions
- Appropriate eating behaviors
- Appropriate sensory regulation behaviors
- Compliance with structured routines

Reinforcement Schedule

Appropriate Functional Communication Responses (FCRs) and newly acquired replacement behaviors will initially be reinforced on a continuous reinforcement schedule (FR1) immediately following emission.

Reinforcement should:

- Be delivered immediately whenever possible (typically within 1-2 seconds)
- Be behavior-specific and clearly connected to the appropriate behavior
- Occur more efficiently and consistently than reinforcement historically associated with maladaptive behavior

As behavioral stability increases, reinforcement schedules may gradually be thinned in a systematic manner to promote increased independence and tolerance for delayed reinforcement.

Noncontingent Reinforcement (NCR)

George should receive frequent, proactive access to reinforcement throughout the day independent of maladaptive behavior to reduce deprivation states and decrease motivation for problem behavior.

Examples may include:

- Scheduled sensory activities
- Scheduled movement opportunities
- Access to preferred items
- Access to attention and engagement
- Small scheduled food portions when clinically appropriate

NCR schedules should initially occur at high rates and may be gradually thinned contingent upon behavioral stability.

Reinforcer Identification & Preference Monitoring

Reinforcement should be individualized based on [redacted] current preferences and motivational state. Staff should continuously monitor for signs of satiation or changes in preference.

Potential reinforcers may include:

- Food items
- Movement activities
- Walking
- Sensory items
- Preferred leisure activities
- Attention and social interaction
- Preferred clothing items or activities

Staff should rotate reinforcement options regularly to maintain effectiveness and reduce satiation.

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Reinforcement Delivery Expectations

Staff should:

- Pair reinforcement with behavior-specific praise
- Deliver reinforcement calmly and consistently
- Reinforce approximations toward replacement behaviors when appropriate
- Reinforce appropriate behavior more frequently than problem behavior receives attention or environmental change
- Avoid unintentionally reinforcing maladaptive behavior through delayed limits, excessive verbal interaction, or inconsistent responding

Reinforcement Thinning & Delay Tolerance

As [redacted] demonstrates increased behavioral stability and successful use of replacement behaviors, reinforcement schedules may gradually be thinned.

Thinning procedures may include:

- Increasing wait duration
- Increasing task expectations
- Transitioning from FR1 to intermittent schedules
- Increasing independence before reinforcement delivery

Thinning should occur gradually and only after stable reductions in maladaptive behavior and consistent demonstration of replacement behaviors.

Reinforcement Integrity & Consistency

All staff must implement reinforcement procedures consistently across settings and activities. Inconsistent reinforcement delivery may strengthen maladaptive behavior through intermittent reinforcement effects.

Appropriate communication and adaptive behavior should consistently result in more immediate, predictable, and efficient access to reinforcement than maladaptive behavior.

Re-Assessment of Problem Behavior:

current program should continue to produce periodic behavior updates that track his progress. Reviews will be conducted with and his Interdisciplinary team (IDT/circle of support). In addition, annual behavioral assessments will be conducted or as needed.

If there are any further questions, please don’t hesitate to contact the evaluator.

Respectfully submitted,

RJ Johnson
Behavior Analyst