Positive Practices in Behavioral Support
Through Non-Linear Applied Behavior Analysis

Facilitator’s Manual

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Los Angeles, California
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GENERAL: The video training program “Positive Practices in Behavioral Support” consists of 19 DVDs and 1 CD. The program is divided into 4 modules with each module being subdivided into sessions. Each module ends with a Roundtable Discussion. This is an interview and discussion with Dr. Gary LaVigna and Dr. Tom Willis by interviewers, Kevin Loeb and Jo Mullins. The discussions expand the content of the material covered in the module.

Listed below are the modules, sessions and runtimes (hours:minutes:seconds):

Series Title: **POSITIVE PRACTICES IN BEHAVIORAL SUPPORT**

Module 1: Nonaversive Behavioral Support and Basic Principles of Positive Programming
Session 1 ...................................... 1:34:35
- Basic Principals
- A Non-linear Model for Nonaversive Behavioral Support
Session 2 ...................................... 47:59
- Ecological Strategies
Session 3 ...................................... 1:22:47
- Positive Programming
Session 4 ...................................... 1:22:51
- Focused Support Strategies
Roundtable Discussions on Module 1:
Sessions 1 – 4 .................................. 1:41:13

Module 2: Comprehensive Functional Assessment and Advanced Support Strategies
Session 1 ...................................... 1:14:56
- Introduction
- Assessment Methods
- Overview of Functional Assessment
Sessions 2 & 3
- Functional Analysis of Behavior ..... 50:43
- History of Behavior ..................... 23:42
Session 4 ...................................... 1:15:43
- Antecedent Analysis
Sessions 5 & 6
- Consequence Analysis ................. 42:22
- Ecological Analysis ...................... 30:44
- Analysis of the Function/Meaning of the Behavior
Sessions 7 & 8
- Stimulus Control ......................... 47:53
- Stimulus Satiation ...................... 34:26
Roundtable Discussion on Module 2:
Sessions 1 – 8 .................................. 1:48:10

Session 1 & 2 .................................. 41:55
- Introduction
- Episodic Severity
- Reasons for Avoiding Traditional Responses to Challenging Behavior
- Ignoring
- Natural Consequences
Session 2 & 3
- The Functions of Behavior ............ 43:20
- Phases of Behavioral Escalation
- Antecedent Control Strategies ....... 1:18:06
- Stimulus Satiation
Session 4 ...................................... 1:42:16
- Reactive Strategies
- Geographical Containment and Inter-Positioning
- Emergency Physical Containment
Roundtable Discussion on Module 3:
Sessions 1 – 5 .................................. 54:50

Module 4: Assuring Staff Consistency and the Provision of Quality Services: An Introduction to an Effective Quality Improvement and Outcome Evaluation System
Session 1 ...................................... 1:51:02
- Introduction
- Background
- The Periodic Service Review
Session 2 & 3
- Performance Standards ............... 53:28
- Performance Monitoring .............. 41:53
Session 4 ...................................... 49:47
- Staff Training
Roundtable Discussion on Module 4:
Sessions 1 – 4 .................................. 20:05
The Modules may be viewed in any sequence; however, we recommend that they be viewed in the sequence presented, i.e., Module 1, 2, 3, then 4. We also recommend strongly that sessions within each Module be viewed in sequence. We have provided the runtimes of each session for your planning purposes.

This manual is provided to assist you in using this video training program effectively. The manual is divided into three sections: Student Lecture Notes for each Module, Study Questions and Answers for each Module, reprints of 5 articles, specifically, Challenging Behavior: A Model for Breaking the Barriers to Social and Community Integration, Behavioral Assessment: An Overview (parts 1 and 2), Severe and Challenging Behavior: Counter-Intuitive Strategies for Crisis Management Within a Nonaversive Framework and Episodic Severity: An Overlooked Dependent Variable in the Application of Behavior Analysis to Challenging Behavior. There are four textbooks included as well. These are: Alternatives to Punishment, Progress Without Punishment, The Behavior Assessment Guide, and The Periodic Service Review.

**CD:** The CD that is enclosed contains this manual in “portable document format” (.pdf) and can be printed using Adobe Acrobat Reader. If you do not already have a copy of Adobe Acrobat Reader or if you receive an error when trying to open these documents, download a free, up-to-date copy from Adobe’s web site (www.adobe.com). This CD is provided so that you can print copies of the lecture notes and reading materials on a “as needed basis.”

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**LECTURE NOTES:** Every person who views this video training program should have their own copy of the lecture notes. This will allow them to follow along with the lectures and make their own notes for future reference.

**STUDY QUESTIONS AND ANSWERS:** The Study Questions and Answers are provided as an additional learning aid. They can be utilized in several ways: as a traditional test to document a person’s knowledge of the material, as a discussion guide for discussion groups that may be held after viewing the DVDs or as an individual study guide for an individual watching the video program.

**ARTICLE REPRINTS:** These four reprints are recommended reading to further your knowledge and understanding of the material presented in the video training program. Please make them available to each person who participates in the training.

**TEXTBOOKS:** The textbooks are recommended reading to further your knowledge and understanding of the material presented in the video training program. Please make them available to each person who participates in the training.
Each person watching this video training program should have a set of lecture notes to refer to while they are viewing the DVDs. These are setup to be duplicated either as a single sided document or as a double sided document.

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(Permission is granted to make copies of the Student Lecture Notes for use with the video training program “Positive Practices in Behavioral Support.”)
Positive Practices in Behavioral Support

Module 1
Nonaversive Behavioral Support and Basic Principles of Positive Programming

Gary W. LaVigna, Ph.D., BCBA-D

IABA

Lecture Notes Prepared By:

Institute for Applied Behavior Analysis®
Gary W. LaVigna
Thomas J. Willis

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TECHNOLOGY IN SUPPORT OF VALUES

**Social role valorization**: The enablement, establishment, enhancement, maintenance, and/or defense of valued social roles for people—by using, as much as possible, culturally valued means (Wolfensberger, 1983).

1. Community presence and participation, in ways that are age appropriate and valued by society.

2. Autonomy and self determination, through the exercise of increasingly informed choice.

3. Continuous involvement in the ongoing process of becoming.

4. Increasing independence and productivity, to the point of economic self sufficiency.

5. The opportunity to develop a full range of social relationships and friendships.
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SESSION 1.

INTRODUCTION

A. The Institute for Applied Behavior Analysis®

B. ABA in Support of Values

1. Social role valorization: The enablement, establishment, enhancement, maintenance, and/or defense of valued social roles for people—by using, as much as possible, culturally valued means (Wolfensberger, 1983)

2. Community presence and participation, in ways that are age appropriate and valued by society

3. Autonomy and self determination, through the exercise of increasingly informed choice

4. Continuous involvement in the ongoing process of becoming

5. Increasing independence and productivity, to the point of economic self sufficiency

6. The opportunity to develop a full range of social relationships and friendships

C. Definition of terms

Punishment:

1. The contingent presentation of a stimulus or event, resulting in a future decrease in response strength.

2. The contingent withdrawal of a stimulus or event, resulting in a future decrease in response strength.

Aversive:

A stimulus or event one would ordinarily act to avoid.

A NON-LINEAR ABA FRAMEWORK
NONaversive BEHAVIoRAL SUPPORT

A. Why people use punishment:

1. Response Alternatives

2. Child rearing practices

3. Modeling effect

4. Literature

5. Expert consultation

6. Myth of effectiveness

7. Reinforcement histories
8. Responses to problem behavior
   a. Treatment
   b. Protection
   c. Anger/aggression/emotion

B. If we wish to change the basic strategies we use, a longitudinal program of behavior change, with us as the learner, is necessary.

C. Ethical considerations:
   1. Conditions
   2. Functionality

D. Administrative and legal considerations:
   1. Legislation
   2. Court findings
   3. Agency rules and regulations

E. Empirical and clinical considerations:
   1. Is punishment necessary for effectiveness?
      a. Speed and degree of effects: over time and within an episode
      b. Durability
      c. Generalization
      d. Side effects
      e. Social validity
      f. Clinical/Educational validity
   2. Interim Summary
### Outcome Measures

- Speed & Degree of Effects
- Durability of Effects
- Generalization of Effects
- Side Effects
- Social Validity
- Educational/Clinical Validity

- Over Time
- Episodic Severity

### Support Plans

#### Proactive Strategies

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<td>• Environmental Pollutants (e.g., noise, crowding)</td>
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#### Ecological Strategies

-• Stimulus Change
-• Crisis Resolution

#### Assessment

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### Mediation

- General Training
- Specific Training
- Compliance
- Natural
- Social Change Agents
- Professional
- Specialized
Breaking the Barriers to Social & Community Integration: A Non-linear ABA Framework for Research, Support and Training

**Assessment**

<table>
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**Support Plans**

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**Service Design**

**Mediation**

- General Training
- Specific Training
- Compliance Natural
- Social Change Agents
- Specialized Professional

**Outcomes**

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**Independent Variables**

- OVER TIME
- EPISODIC SEVERITY
EcoIogical Strategies

A. Definition: Changes in the physical, interpersonal and programmatic environment to better fit the person’s characteristics and needs.

B. Physical Factors
   1. Examples
      a. Setting
      b. Light
      c. Noise
      d. Crowding
   2. Implications

C. Interpersonal Factors
   1. Examples
      a. Peer respect
      b. Communication/culture
      c. Social interactions
      d. Expectations
   2. Implications

D. Programmatic Factors
   1. Examples
      a. Choice, predictability, and control
      b. Motivational system
      c. Curriculum
         1) Goals and objectives
         2) Tasks and materials
      d. Task difficulty
      e. Instructional methods
   2. Implications
SESSION 3

POSITIVE PROGRAMMING

A. Definition: Longitudinal instruction designed to teach skills and competencies to facilitate behavioral changes for the purpose of social integration.

B. Variations

1. General instructive program
   a. Functional
   b. Chronologically age-appropriate
   c. Low inference

2. Teaching functionally equivalent skills
   a. Communication skills
      1) Examples
         a) Ringing bell vs. crying
         b) Word card vs. hitting
         c) Communicating confusion
         d) Saying “No”
      2) Choosing augmentative systems
      3) Instructional strategies
   b. Independence

3. Teaching functionally related skills
   a. Discrimination
   b. Choice
   c. Predictability and control
   d. Rules
   e. Stimulus control

4. Teaching coping skills
   a. Desensitization
   b. Shaping
   c. Relaxation training
SESSION 4

FOCUSED SUPPORT STRATEGIES

A. Definition: A strategy to reduce and, if possible, eliminate the need for a reactive strategy

B. Time-based schedules
Increase the density of time-based delivery of preferred events.

C. Differential schedules

1. Differential Reinforcement of Other Behavior (DRO)
   a. Definition: Reinforcement after a specified period of no undesired responding.
   b. Examples:

   
<table>
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   c. Variations

   1) DRO reset schedules
   2) DRO fixed interval schedules
   3) DRO progressive schedules
   Definition: A DRO schedule of reinforcement involves the progressive increase of reinforcement available for each consecutive interval during which target behavior does not occur up to a specified maximum.
   4) Momentary DRO schedules
   5) Trial by trial-omission training
   6) DRO escalating (increasing interval) schedules

d. Implementation

   1) Selection of target behavior
   2) Selection of DRO variation
   3) Selection of time interval
      a) Goldilocks Rule
      b) Fixed interval: 50% of the average time between responses before intervention.
   4) Selection of reinforcers
a) The Free Access Rule
The maximum amount of positive reinforcement available during intervention must be less than the person would seek given free access.

b) General considerations
5) Fading of reinforcers
6) Positive programming
e. Advantages
1) Lack of behavioral contrast
2) Generalization of effects
3) Minimal, if any, negative side effects
4) Speed of effects
5) Resistance to recovery
6) Social validity
f. Cautions
1) Non-constructive
2) Inadvertent reinforcement

2. Differential Reinforcement of Low Rates of Responding (DRL)
a. Definition: The reinforcement of the undesired response, if more than a specified period of time has elapsed since the last response, or if fewer than a specified number of responses occurred during a preceding interval of time.
b. Examples:

DRL

\[
\begin{array}{c}
\text{High Rate Behavior} \\
\text{Low Rate Behavior}
\end{array}
\]
c. Implementation
1) Response rate
2) Learner ability
3) Interval size and reinforcement criteria
4) Changing criteria
5) Reinforcement magnitude
d. Advantages
1) Success with high rate behaviors
2) Flexible interval size
3) Ease of implementation
4) Reinforcement frequency
5) Tangible feedback
6) Speed of effects
7) Potential for group contingencies
8) Potential for completely eliminating behaviors

e. Cautions
1) Non-constructive
2) Concerns regarding social validity
3) Minimize potential for aversive component
   a) Student controlled
   b) Matter-of-fact
   c) Non-exchangeable
   d) Non-interruptive
   e) Link failure with opportunity

3. Differential Reinforcement of Alternative Responses (ALT-R)
   a. Definition: The reinforcement of specified behaviors that are topographically different from the undesired response.

   b. Examples:

   c. Variations
   1) DRA
   2) DRI
   3) The 100% rule: The target behavior and the alternate response, taken together, represent the universe of possibilities.
d. Implementation
   1) Meet 100% rule or approximate
   2) Specify reinforcement schedule
      a) Free access rule
      b) Mediating systems
   3) Natural contingencies

e. Advantages
   1) Lasting results
   2) Constructive
   3) Social validity

f. Concerns
   1) Delayed effect
   2) Complexity and mixed evidence
   3) Recovery and rebound

**CONCLUSIONS**


Positive Practices in Behavioral Support

Module 2
Comprehensive Functional Assessment and Advanced Support Strategies

Thomas J. Willis, Ph.D.
TECHNOLOGY IN SUPPORT OF VALUES

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SESSION 1

FUNCTIONAL BEHAVIORAL ASSESSMENT

The basis of a Comprehensive Support Plan

Answers the Question:
"Why is the person engaging in the behavior(s)?"

PERSON CENTERED BEHAVIORAL SUPPORTS

Behavioral Assessment

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Multielement Support Plan

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Mediation

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Outcomes

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<th>Side Effects</th>
<th>Social Validity</th>
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FUNCTIONS/MEANING OF BEHAVIOR

From the Person’s Perspective
Linear Conclusion: Attention/Escape/Self-Stimulation

- Communication
  - “Go Away!”
  - “I Want.”
  - “I’m Confused

- Acquire/Obtain
  - Food
  - Attention

- Escape/Avoid
  - Demand
  - Loud Noise
  - Task
• Increase/Decrease Sensory Stimulation
  – Tactile/Vibration
  – Intense Smell
  – Lights Flickering

• Manage Negative Emotions
  – Anger at Being Touched
  – Anxiety Around Loud Noise
  – Anger at Criticism

• Social Interaction
  – Greeting
  – Play

• Neurological/Psychiatric

  Traditional Behaviorism
  Linear Approach

• 7-year old girl with severe disability

• Manifests an eating disorder

• Traditional Assessment
  — Problem is one of noncompliance

• Traditional Management Plan
  — Extinction of noncompliance
  — Forced feeding

• Possible New Analysis
  — Missing a critical skill

• Non-Traditional Approach
  — Stimulus Transfer
### Assessment Methods

- Direct Observation/Interaction
- Probes/Role Play/Direct Manipulation
  - Iwata and Colleagues: Social disapproval, academic, unstructured play, alone
- Records Review
- Interviews
- Rating Scales/Screening Forms
  - Mark Durand: Motivational Assessment Scale (MAS)
  - Reinforcement Inventory
- Data Reduction/Analysis
- Report Writing: Putting together the pieces of the jigsaw puzzle

Kanfer and Saslow, 1969, Behavioral Diagnostics

*A behavioral analysis excludes no data relating to a patient’s past or present experiences as irrelevant.*
OvervieW of FuncTioNaL AssessmenT

Referral Information

Description of the Person
- Physical Characteristics
- Likability
- Cognitive Abilities
- Communication Abilities
- Self-Care Skills
- Social Skills
- Community Skills
- Domestic Skills
- Leisure/Recreation Skills

Other Background Information
- Family History and Background
- Living Arrangement
- Program Placement
- Health and Medical Issues
- History of Treatment

Functional Analysis of Behavior

Mediator Analysis

Motivational Analysis

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Carrying heavy groceries from the store to home 16
Calling parents too many times .................. 17
Checkbook hiding place ........................... 18
Getting evicted ................................ 19
Etc

Arriving Late To Dr’s Appointment
- When I am afraid of being late for my Dr’s appointment, I won’t die
- Many people are late for Dr’s appointments
- Dr’s are often late for appointments
- There are lots of things I can do to make sure that I will be on time.
- I can
  – Check my weekly planner to make sure that I won’t forget my appointment time
  – Leave early to give myself extra time to arrive at the doctor’s office
  – I can call the doctor and tell him that I might be late
  – Make a new appointment if I have missed it
SESSION 2

FUNCTIONAL ANALYSIS OF BEHAVIOR

A. The PURPOSE of a Functional Analysis
   • Identify Events That CONTROL Behavior
   • Determine FUNCTION of Behavior

B. Functional Analysis of Behavior
   • Description of Behavior
   • History of Behavior
   • Antecedent Analysis
   • Consequence Analysis
   • Ecological Analysis
   • Analysis of Function/meaning

C. Description of Problem Behavior

   The Goals Are:

   1. Paint A MENTAL PICTURE of what the person does
   2. Answer the question: “How do you know you have been hit? Spat at? Verbally abuse?”

D. Inadequate Definitions

   • Trish hits other students during recess when she does not get her way
   • Carlos makes irrelevant and inappropriate comments during class discussion
   • Behaviors associated with Attention Deficit Disorder, and
     – Behaviors associated with Obsessive Compulsion, and
     – His attention getting behaviors
   • Perseverative thinking, and
     – Not task, and
     – Sometimes not situationally relevant

Labels/Not Definitions
   • Hyperactive
   • Short Attention Span
   • Aggressive
   • Compulsive
   • Obsessive
   • Panicky
   • Anxious
• Avoids School
• Tardy
• Perseverative

More Inadequate Definitions
• lots of temper tantrums
• bad tantrum
• brief tantrum
• tantrum all through the day
• screaming tantrum
• threw a fit
• kept going off
• came close to hitting
• wanted to bite a lot
• lots of biting and kicking
• tried to go after me a number of times
• attacked me
• wanted to scratch
• kick lots
• attacking me all the time
• melted down
• got me good today
• went for my shirt
• went for my fingers

Four Components of a Behavioral Description

1. Topography of behavior
2. Measurement Criteria
   a. Cycle of behavior
   b. Episodic severity of the behavior
3. Course (progression) of behavior
4. Strength of behavior
   a. Occurrence
   b. Episodic Severity

Topography of the Behavior

• What exactly does the person DO to behave in a particular way?
• What are the physical characteristics of the behavior?
  — What does the behavior look like?
  — What does the behavior sound like?
  — What does the behavior SMELL like?
  — What does the behavior TASTE like?
  — What do others report?
  — What does the person report?
Target Behaviors (More Labels)
- Off Task vs. On Task
- Tardy vs. On Time
- Profanity
- Noncompliance
- Verbal abuse
- Inappropriate sexual behavior
- Inappropriate touching

Measurement Criteria: Recording Cycle

Event Recording
- At what point does the behavior/Event START and STOP?
  - Onset:
    - Scream for 5 continuous seconds
    - First contact of fist to nose
    - Failure to start within 5 seconds of 1st request
  - Offset:
    - Screaming absent for 5 minutes
    - Contact has ceased
    - Five minutes from 1st request or is involved in activity
  - Percent of Opportunity:
    - Failure to initiate/non-performance begins if fails to initiate the requested activity within 5 seconds of the 1st request
  - Interval Recording:

Measurement Criteria: Episodic Severity
- How will severity of AN EPISODE be measured?
  - Duration?
    * Total amount of time of each episode
  - Frequency Per Episode?
    * Level 1 = 1 to 5 hits
    * Level 2 = 6 to 10 hits
    * Level 3 = More than 10 hits.
  - Cost of Damage?
  - Injury on a 4-point scale
    * 1 = No Injury, first aid, medical attention
    * 2 = More than one contact/No first aid or medical attention
    * 3 = First aid required
    * 4 = Medical attention required
### A comparison of episodic severity vs. measures of severity over time

<table>
<thead>
<tr>
<th>Target Behavior</th>
<th>Baseline</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outbursts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Over Time</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td>10/week</td>
<td>2/week *</td>
</tr>
<tr>
<td>Duration</td>
<td>10 hours/week</td>
<td>4/hours/week *</td>
</tr>
<tr>
<td><strong>Episodic Severity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avg. Duration</td>
<td>1 hr./episode</td>
<td>2 hr./episode **</td>
</tr>
</tbody>
</table>

* Improvement  
** No Improvement

### A comparison of episodic severity vs. measures of severity over time

<table>
<thead>
<tr>
<th>Target Behavior</th>
<th>Baseline</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Aggression</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Over Time</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td>10/month</td>
<td>3/month *</td>
</tr>
<tr>
<td>Episodes resulting in hospital trips</td>
<td>7 month</td>
<td>3/month *</td>
</tr>
<tr>
<td><strong>Episodic Severity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of episodes resulting in hospital trips</td>
<td>70%</td>
<td>100% **</td>
</tr>
</tbody>
</table>

* Improvement  
** No Improvement

Course of the Behavior Over Time

- From start to finish, what does the behavior look like?

Frame by frame description

- Does the behavior start gradually or full blown?
- Describe recent episodes

Examples of Behavioral Precursors

- Head Down > Fiddles > Bolts
- Paces > Pounds > Yells > Hits
- Repetitive Question Asking
- Spaced Out > Eyes Roll Up
- “I’m Going To Hit You!”
- Fixed Eye Contact For 30”
- “You’re Not My Mom”
- Push Work Away > Head Down
- Under Desk > Strip Naked
In some instances there may be no warning signs at all. the behavior may just start

In some instances the may be no gradual de-escalation. the episode may just stop

There may be multiple courses: mild, severe, differ depending on where and with whom

Strength of Behavior

- Occurrence Over Time
  - Rate per day/week/month
  - % of Noncompliance per hour/day/month
  - Severity over time
    - Duration per hour/day/month
    - Number of items broken per day/wk/month

- Episodic Severity
  - Average duration of a tantrum in minutes
  - Average damage per episode
  - Percentage of episodes that result in hospitalization
  - Percentage of episodes that exceed a “4” rating on the severity scale

- Quality of Life Effects

Quality of Life Outcomes

- Living arrangement
- Freedom from restraints
- Frequent family contact
- Community participation
- Choice and control
### SESSION 3

#### HISTORY OF THE PROBLEM BEHAVIOR

History of the Problem Behavior

- Is HISTORY important? The MYTH of unimportance

- Implication of a good HISTORY
  - Need for behavioral strategies
  - Origin of behavioral challenges
  - Type of treatment strategies

- Determine the RECENT and LONG-TERM history of the behavior

- When did the behavior first appear?

- The impact of a long history
  - More opportunity for reinforcement
  - Greater habit strength
  - Slower treatment progress

- Does the behavior cycle from high to low at regular intervals?
  - Self-injury and operant vomiting
  - Cycling psychiatric problems
  - Bi-polar

- Have there been any recent INCREASES or DECREASES in the behavior?
  - May help identify reason for problem!

- Have there been any SUDDEN CHANGES in the person’s life?
  - Changes in residence?
  - Change in school or bus schedule?
  - Daylight savings time?
  - Full moon

- Have there been any UNIQUE UPSETTING events?
  - Divorce?
  - Marital discord?
  - Loss of a loved one?
  - Sexual or physical abuse?
  - Financial problems?
**SESSION 4**

**ANTECEDENT ANALYSIS**

Antecedent Analysis

- What events the INCREASE and DECREASE the LIKELIHOOD of the behavior?

- What events CUE, SET OFF or TRIGGER the behavior or ALTERNATIVES

- WHERE, WHEN, and with WHOM is the behavior MORE or LESS likely to occur?

Methods for Antecedent Analysis

- ABC Analysis
- Incident Reports
- Interviews
- Probes/Analog Conditions
- Formal Manipulation of Antecedents
- Present Antecedent and See What Happens?????
- Antecedents for alternatives/absence (record what the person is doing)

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Antecedent</th>
<th>Behavior</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>______</td>
<td>_____<em>very angry because his b</em> _ _ h mom yelled at him for &quot;no reason&quot;</td>
<td>He had to be persuaded to do his morning work</td>
<td>The afternoon was very good. He was very polite when he went to the office and earned computer time.</td>
</tr>
<tr>
<td>Date &amp; Time</td>
<td>Antecedent</td>
<td>Behavior</td>
<td>Consequences</td>
</tr>
<tr>
<td>-------------</td>
<td>------------</td>
<td>----------</td>
<td>--------------</td>
</tr>
<tr>
<td>4/23 11:50 AM</td>
<td>On way to rest room</td>
<td>Student asked to use the rest room</td>
<td></td>
</tr>
<tr>
<td></td>
<td>On way to rest room OS called him “Fatso”</td>
<td>Began cursing “F_ _ _ _ You,” gave finger and threatened to kick OS’s ass</td>
<td>Asked Student to ignore OS</td>
</tr>
<tr>
<td></td>
<td>Returned to class after using bathroom</td>
<td>• Looking for OS  • Called out for OS. Threatened to “kick his ass”</td>
<td>I asked Student to come to class</td>
</tr>
<tr>
<td></td>
<td>I asked Student to come to class</td>
<td>He refused</td>
<td>Asked BS if Rod was around</td>
</tr>
<tr>
<td></td>
<td>Asked BS if Rod was around</td>
<td>Began to yell “No, no”</td>
<td>If you come to class you can talk to Rod</td>
</tr>
<tr>
<td></td>
<td>If you come to class you can talk to Rod</td>
<td>Became very angry, started yelling and kicking</td>
<td>I tried to open the door to get help</td>
</tr>
<tr>
<td></td>
<td>I tried to open the door to get help</td>
<td>He began kicking me. I had to hide behind my desk</td>
<td>Rod entered the room</td>
</tr>
<tr>
<td></td>
<td>Rod entered the room.</td>
<td>He began throwing the desks and saying “keep away”</td>
<td>Rod took him down</td>
</tr>
</tbody>
</table>
Internal Events
- Organic Events
- Chemical Events
- General Health

External Events
- Places
- Persons
- Objects
- Time of Day, Week, Month
- Activities

Cognitive Events
- Attributions
- Perceptions (Injustice Done)
- Beliefs - Prejudice
- Catastrophic Thinking
- Voices Told Me

Setting Events
- Mood
- Psychiatry
- Illness
- Sleep
- Constipation
- Medication Change
- Earlier Argument
- Financial Troubles
- Loss of Loved One
- Satiation (Big Meal)
- Time Change

Triggers
A - - - - - - - B - - - - - - - C
Direction
Criticism
Cut Off in Traffic
Math
Being Ignored
Person
Place

Internal Environment
(What internal events INCREASE or DECREASE the LIKELIHOOD of the behavior?)
- General Health
- Feelings of WELLNESS
- Pain
- Sleep Deprivation
- Chemical Environment
  - Type
  - Dosage
  - Schedule
- The Feeling of Anxiety
External Environment

WHERE? (What places, settings, or locations INCREASE or DECREASE the LIKELIHOOD of the behavior?)

"If I want him to hit me, where should I go?"
"If I don't want him to hit me, where should I go?"

- Home vs. School
- Home vs. Community
- Classroom A vs. Classroom B
- Playground vs. Classroom
- Bathroom Only

External Environment

WHOM? (With whom are the behaviors MORE or LESS the LIKELY to occur? Any characteristic which will discriminate one person from another can be an antecedent)

- Sex
- Age
- Race
- Physical Characteristics
- Attitude (doesn't like the person)
- Philosophy

External Environment

WHEN? (When, what time, are the behaviors MORE or LESS the LIKELY to occur?)

- Time of day, week, month
- Bed wetting at 5:30 a.m
- Aggressive at 6:00 p.m. just before meals
- Explore events at these times
- Scatter plot method (Paul Touchette)
External Environment

WHAT? (What specific events or activities INCREASE or DECREASE the LIKELIHOOD of the behavior?)
"If I want him to hit me, what would I have to do?" Top 10
"If I don’t want him to hit me, what would I have to do?" Top 20

- Demands vs. Requests
- Math vs. History
- Interactions (dignifying or not)
- Teasing/Criticism/No/Evil Eye
- Enter Personal Space
- Noise vs. Quiet
- Number of People in the Room
- 5 Math Problems vs. 10
- 15 minute task vs. 30 minute
- "Do your math!" vs. "Would you please..."
- Wanda and Screaming/Noise

Look at the ABCs and the logs.
SESSION 5

CONSEQUENCE ANALYSIS

Consequence Analysis

- Identify events reinforcing the problem behaviors
- Identify events punishing desirable alternative behaviors
- Identify events/reactions that resolve the behaviors
- Identify and evaluate previous treatment strategies

INTERNAL ENVIRONMENT
- Sensory Feedback
- Increased Anxiety
- Decreased Anxiety
- +/- Anger, etc
- Sensations

EXTERNAL ENVIRONMENT
- Reactions
- Threats
- Removal/Escape
- Attention
- Environmental Change

COGNITIVE ENVIRONMENT
- Attributions
- Perceptions
- Beliefs

Key Questions in Consequence Analysis

1. How do people react when the behavior occurs?
   - Ignore
   - Walk away
   - Yell
   - Give in

2. What is the immediate effect on the behavior?
   - Screams louder
   - Grabs, Screams
   - Smiles and stops
   - Behavior stops

3. What is the long-term effects of the REACTIONS?
   - Worsen?
   - Improve?
   - Remain the same

Build a Catalog of Consequences!
Why We Juxtapose These Two Questions?

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Consequence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R</strong> Functions</td>
<td><strong>S</strong></td>
</tr>
</tbody>
</table>

1. What is the impact of achieving the goal?
2. What is the impact if the goal is not achieved?

What is Gained by the Behavior?
- Attention
- Come Closer
- Everyone Looks
- Food
- Hug/Touch/Restraint
- Reaction
- How High People Can Jump?
- The Environment Changes
- Conversation
- Someone Solves A Problem
- Change
- Gets Labels From Clothing

What is Escaped or Avoided?
- Demand Removed
- Takes A Break
- Relieves Feelings of Stress
- Doesn’t Have To Do ______
- Radio Is Turned Down
- Boring Task Is Removed
- Give Medication - Pain Removed
- Leave Alone
- Doesn’t Have To Go With Housemates
- Nagging Person Leaves Or Quits Nagging
- Restraints Given >>> Task Can’t Be Done
- Escape Swings
- Avoid Big Dogs
- Escape/Avoid Typewriters

What Programs Have Been Used To Manage Behavior?
- What Programs Have Been Effective?
- What Programs Have Failed? Why?

- Implementation Issues?
  - Rules of Good Contingency Management?
  - Ever Implemented?
  - Consistency?
  - Client’s Cognitive Ability/Understanding?

Some Rules of Reinforcement
- Meaningfulness
- Contingency of Reinforcement
- Deprivation/Satiation
- Immediacy of Reinforcement
- Frequency of Reinforcement
- Amount of Reinforcement
- Amount of Work Required
- Reinforcer Novelty
- Reinforcer Variety
- Reinforcer Sampling
- Rule (Exposure)
- Competing Contingencies
- Schedules of Reinforcement
- Size of DRO Interval
- Tangible Monitoring
- System for DRL
- Concrete Presentation
- And So On
SESSION 6

ECOLOGICAL ANALYSIS

Purpose of an Ecological Analysis

- Identify mismatches between the person and the ecology
- That may contribute to the behavior challenge and/or
- Detract from the person’s quality of life

Where do we find ecological conflicts?

Physical Factors

- Setting (e.g., size/location/cleanliness/security/clutter)
- Lighting (e.g., fluorescent lighting, too bright/dark)
- Noise
  - Proximity to door/pencil sharpener
  - DTT carried out in distracting environment
- Number of Persons in Setting (e.g., crowding/proximity)
- Behavior of Others in Setting (Contagion)
- Sudden Changes in Living/Working Environment
- Classroom Ecology
  - Location in the Classroom
  - Arrangement of Desks in Classroom
  - Tables vs. Desks

Interpersonal Factors

- Expectations Of Others
  - Too Low/Too High
- Quantity And Quality Of Interactions
- Culture Of Respect And Dignity
- Physical Characteristics Of Support Staff
  - Sex, Color, Size
- Personality Of Support Staff
- Interpersonal Likes And Dislikes Of Staff
  - Feces Smearing
— Directed Spitting
— Physical Aggression
— Genital Touching
— Focused Verbal Abuse

Philosophical Factors

• Spare the Rod, Spoil the Child
• All Kids Need Discipline/Consequences
• All Kids Must Be Treated Equally
  — If hit, suspended!
  — What will other kids think?
• All Kids Must Follow The Same Rules
  — Stay in class!
  — No blurting out!
• Kids With Behavior Problems Don’t Belong In Class
• Not Like Real People
• My Job Is To Teach, Not Manage Behavior
• Bad Characters, Willful

Programmatic Factors

• Opportunity for Choice
• Predictability and Control
  — Concrete Schedules/Day Planners/Calendars
  — Individual/Group Schedule
  — List of Rules
• Motivational Systems
• Task Related Issues
  — Interest/Difficulty/Order/Length
• Task Difficulty – Task Order – Task Length
• Instructional Methods and Cognitive Style
  – Auditory Learner – Visual Learner – Motor Learner
  – Response Priming – Chain Interrupt – Correction Method
Curriculum – Adapted Tasks and Materials

**ANALYSIS OF THE FUNCTION/MEANING OF THE BEHAVIOR**

The Inferential Leap

- Wanda attacks vacuums
- Finger – Finger – Throw
- Pizza and Chocolate Ice Cream
- Refuses to go to school

Functions/meaning of behavior (from the person's perspective)

- Communication
  - “Go Away!”
  - “I Want.”
  - “I’m Confused”

- Acquire/Obtain
  - Food
  - Attention

- Escape/Avoid
  - Demand
  - Loud Noise
  - Task

- Increase/Decrease Sensory Stimulation
  - Tactile/Vibration
  - Intense Smell
  - Lights Flickering

- Manage Negative Emotions
  - Anger at Being Touched
  - Anxiety Around Loud Noise

- Social Interaction
  - Greeting
  - Play

- Neurological/Psychiatric

Implications

- Teaching better ways of communicating
- Teach better ways of reducing stress, anxiety, frustration
- Teach better social/play skills
- If skill is absent - teach it
- If skill is present but unused, increase use
SESSION 7

STIMULUS CONTROL

Definition: In the presence of certain stimuli the behavior is more or less likely to occur

Examples of Stimulus Control

Telephone rings > > > > > Answer the phone
11AM > > > > > > Look for mail
Back of the bus > > > > > Take clothes off
Stop sign > > > > > Stop
Question > > > > > Answer the question
8 PM > > > > > Telephone appointment

Stimulus Control Variations

• Establishing Stimulus Control (Positive Programming Strategy)
• Antecedent Control (Focused Support Strategy)
• Fading/Transfer of Stimulus Control (Positive Programming Strategy)

Establishing Stimulus Control: Method

\[ S^d \rightarrow R \rightarrow S^+ \]

Condition 1: Reward

\[ S^d \rightarrow R \rightarrow \times \]

Condition 2: Extinction

Establishing Stimulus Control: Counseling Time

Counseling Time

Talk and Complain

Opportunity to Talk and Complain

No Counseling

Talk and Complain

"Wait for Counseling Time."
Establishing Stimulus Control: Spitting and the Red Shirt

Establishing Stimulus Control

- Masturbation
- Self Injurious Somersaulting
- Talk Time and Breaks in Classroom
- John’s Random Spitting
- Sucking Thumb - A Time and a Place
- Eating Cigarettes
- Taking Off Clothes
- Bizarre/Psychotic talk
- Compulsive Coffee Drinking
- Obsessive Compulsive Hand Washing
- Obsessive Compulsive Retracing
- Screaming To Ride in the Car
- Running Time

Implementation Issues

- Choice of Target Behavior
  - Perseverative Behaviors (High rate stereotypic behaviors, some problematic verbal and sexual behaviors)
  - Don’t establish stimulus control of dangerous or damaging behaviors. USE antecedent control strategies

- Selection of the Reinforcer
  - Mostly intrinsic
  - Sometimes need extrinsic to get started

- Selection of the Discriminative Stimulus (Sd)
  - Be careful (e.g., masturbation in the bathroom, this can lead to some serious problems if the person can’t discriminate between his bathroom at his home and the public bathroom)
  - Socially acceptable conditions (e.g., place, time, question)
  - Artificial stimulus control
    - Not readily available in community outside of training condition (e.g., red shirt and spitting, bell ringing and free time)
    - Fade to natural stimulus conditions
Antecedent Control Strategies

- Used with very serious behaviors
- Involves:
  - Identification of stimulus conditions where behavior does and does not occur through an "Antecedent Analysis"
  - Use of this information to insure the absence of the problem behavior

Transfer of Stimulus Control

\[ S^d_1 \rightarrow S^d_2 \rightarrow S^d_3 \rightarrow S^d_4 \rightarrow S^d_5 \rightarrow R \rightarrow S^+ \]
SESSION 7

STIMULUS SATIATION

Stimulus Satiation

- The continuous and non-contingent availability of the identified reinforcer maintaining the undesired behavior
- Thereby weakening its effectiveness and reducing the rate of the defined behavior

Case Study of Towel Hoarding (Ayllon, 1963)

- 47 year old woman diagnosed as chronic schizophrenic
- Hospitalized 9 years
- Kept 19 to 29 towels in room
- Spent time folding towels
- Procedure:
  - Week 1, Given 7 towels a day
  - By Week 3, Given 60 towels a day
- Results
  - Week 1 - "You found some for me."
  - Week 2 - "No more Towels."
  - Week 3 - "Take them away. I can’t stay up all night folding."
  - Maximum - 625 towels - Started removing
  - 0 by end of 26 weeks
  - 1 - 5 towels in 12 months

Examples
- Pica
- Coffee Drinking
- Tantrums for Attention
- Peeping
- Hoarding
- Stealing Cars
- Scavenging
- Rast et al (1985) Regurgitation
- Getting a drink
- "Go home, go home!"
- Chewing on clothing

Case Studies
- Young man eats feces, grass, leaves, lint, food
  - Incidents occur about every 45 minutes
— Discrimination Test
— Assessment established preferences through structured access every 30 minutes
— Behavior maintained by opportunity to eat
— Provide access to food about every 30 minutes
— Fade to natural times to eat
— Incidents of Pica decreased dramatically

**Pica**

<table>
<thead>
<tr>
<th>Function</th>
<th>Opportunity to Ingest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feces</td>
<td></td>
</tr>
<tr>
<td>Leaves</td>
<td></td>
</tr>
<tr>
<td>Lint</td>
<td></td>
</tr>
<tr>
<td>String</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide access to food every 30 minutes</td>
</tr>
<tr>
<td></td>
<td>Fade to natural snacks</td>
</tr>
</tbody>
</table>

1. Determine ability to discriminate
2. Determine free access - satiation level
3. Determine IRT

• Coffee Addict
  — Young man
  — Constantly seek out coffee
    > Rush and push to get to coffee pot
    > Would scald self as attempts to quick drink
    > Workshop had to hide all coffee to prevent dangerous behavior
  — Free access assessment. Drank approximately 28 cups of coffee in about 6 minutes
  — Vomited
  — Every 15 minutes given access to cup of coffee
  — Gradually faded to breaks
Hoarding and Scavenging

AWOL to collect tinfoil

Opportunity to Twiddle

Provide different grades of tinfoil in the facility. One grade for free, other as reinforcement.

30-year-old woman spends much of her time in the community collecting bits of tinfoil

Assault to get labels

Collection of Labels

Variations

- Continuous availability
- Non-continuous availability, but significantly greater than free-access level
  - Scheduled delivery
- Distinguish from "Overcorrection (OC)"
  - OC focuses on response not reinforcer
  - Satiation focuses on reinforcer
  - NO FORCED RESPONDING
  - Not NEGATIVE PRACTICE

Implementation Issues

- Analysis of identifying reinforcer
- Non-contingent availability
- Continuous high-levels of availability
- Indefinite availability or bring under stimulus control
- Natural availability
  - Meals
  - Therapy
  - Whenever you ask (snack, get it yourself)
- Use with combination of Positive Programming
  - Stimulus satiation teaches nothing


Positive Practices in Behavioral Support

Module 3
Emergency Management and Reactive Strategies Within a Positive Practices Framework

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Lecture Notes Prepared By:
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**SESSION 1**

**INTRODUCTION**

A. A Non-Linear Multielement ABA Framework for Person-Centered Behavioral Supports: An Overview

1. Technology in Support of Values

   Social role valorization: The enablement, establishment, enhancement, maintenance, and/or defense of valued social roles for people—by using, as much as possible, culturally valued means (Wolfensberger, 1983)

   a. Community presence and participation, in ways that are age appropriate and valued by society
   
   b. Autonomy and self determination, through the exercise of increasingly informed choice
   
   c. Continuous involvement in the ongoing process of becoming
   
   d. Increasing independence and productivity, to the point of economic self sufficiency
   
   e. The opportunity to develop a full range of social relationships and friendships

2. Valued outcomes

3. Person-Centered Assessment: Why?

   a. Positive Futures Planning
   
   b. Comprehensive Functional Assessment

| A. Referral Information
| B. Description Of The Person
  | • Physical Characteristics
  | • Cognitive Abilities
  | • Communication Abilities
  | • Motor/Perceptual Abilities
  | • Self-Care Skills
  | • Social Skills
  | • Community Skills
  | • Domestic Skills
  | • Leisure/Recreation Skills
| C. Other Background Information
  | • Family History and Background
  | • Living Arrangement
  | • Program Placement
  | • Health and Medical Issues
  | • Service History
| D. Mediator Analysis
| E. Motivational Analysis
| F. Functional Analysis of Behavior
  | • Description of Problems
  | • History of Problems
  | • Antecedent Analysis
  | • Consequence Analysis
  | • Ecological Analysis
  | • Impressions and Analysis of Meaning

Table 1 - Major Areas of Focus in a Comprehensive Behavioral Assessment
3. Multielement Support Plans:
   a. **Environmental** strategies and **quality of life** as a process strategy
   b. **Positive Programming**
   c. The role of **Focused Support strategies**: To reduce/eliminate the need for reactive strategies
      1) Is Punishment necessary?
      2) Implications of a nonaversive approach
         a) The need for reactive strategies
         b) Social validity
   d. The role of **Reactive strategies**:
      1) Rapid and safe situational management, i.e., to reduce episodic severity
      2) The distinction between proactive and reactive strategies
      3) In a multielement approach, reactive strategies are liberated from their responsibility for any future effects. That function is reserved for proactive strategies. This includes the responsibility for preventing any counter-therapeutic effects that might otherwise be caused by the reactive strategies
      4) Implications
      5) Examples

4. Mediation
   
   Breaking the barriers to social and community integration; A Non-linear ABA Framework for Research, Support and Training

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<tr>
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<th>GENERALISATION OF EFFECTS</th>
<th>SIDE EFFECTS</th>
<th>SOCIAL VALIDITY</th>
<th>RE-CUSTOMISATION</th>
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B. Conceptual introduction: The implications of Episodic Severity as a dependent variable

1. Applied Behavior Analysis (ABA) involves the application of the principles and procedures of behavioral psychology to human behavior in all settings

2. ABA is characterized by its objectively and reliably measured changes in behavior as a result of equally clearly defined procedures

3. One field in which ABA has made a significant contribution is the field of challenging behavior

4. ABA forms the basis for IABA’s Non-linear Multielement Model

5. Episodic Severity: A measure of the intensity or gravity of a behavioral incident

6. Episodic severity measures would include:
   a. Duration
   b. Cost of repair or replacement
   c. Degree of harm or injury
   d. Topography
   e. Severity ratings based on categories or scales

   **OF EACH INCIDENT**

7. ABA has not identified episodic severity as a dependent variable

8. Since ABA has overlooked episodic severity as a dependent variable, practitioners have had to look elsewhere for reactive strategies

9. The role of a reactive strategy is to reduce or minimize episodic severity

10. We believe that ABA can make a contribution to this important area, and therefore, should begin to explore episodic severity as a new dependent variable and develop an effective technology for reducing episodic severity

11. For ABA to do this suggests a review of basic principles and procedures, as they have been historically defined in terms of their impact on the future probability of behavior

12. Considering their corollary, situational effects may provide a starting point for the development of effective reactive strategies
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**FUTURE EFFECTS MATRIX**

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<td>Negative Reinforcement</td>
<td>Type II Punishment</td>
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<td>O</td>
<td>Recovery After Punishment</td>
<td>Extinction</td>
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**SITUATIONAL EFFECTS MATRIX**

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<td>Type II Escalation</td>
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<tr>
<td>Resolution After Escalation</td>
<td>Escalation After Resolution</td>
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*Figure 2*
C. Examples:

1. Positive Resolution: In a supermarket, a child starts whining and crying, while pointing to the candy counter. Mom provides the child with her doll and baby bottle and asks her to feed her “baby” because she is hungry. The child is distracted and ES is minimized.

2. Negative Resolution: In a serious case of “life-threatening” self injury and aggression, rapid and safe resolution was possible and the need for medical attention was avoided when staff realized that if they left the area at the start of episode, the client would cease exhibiting the target behavior, thereby reducing ES.

3. Type I Escalation: Our functional assessments have revealed that physical “prompts” to force performance, as is sometimes done in compliance training programs, can escalate behavior to crisis levels, thereby increasing ES.

4. Type II Escalation: Our functional assessments have revealed that physically removing a child from a classroom as part of a “time-out” procedure for disruptive classroom behavior, can escalate behavior to crisis levels, thereby increasing ES.

5. Escalation After Resolution: Our functional assessments have revealed that initiating an escape extinction procedure, for example, for Self-Injury, can result in increases in ES.

6. Resolution After Escalation: We have recommended discontinuing the use of physical prompts when they have been associated, through a functional assessment, with an escalation in behavior, resulting in decreases in ES.
SESSION 2

REASONS FOR AVOIDING TRADITIONAL RESPONSES TO CHALLENGING BEHAVIOR

A. Reasons for avoiding traditional responses to challenging behavior

1. Punishment
   a. Definition: The contingent presentation or withdrawal of a stimulus or event which produces a future decrease in response strength
   b. Administrative and legal considerations
   c. Empirical considerations:
      1) Dangers of elicited and evoked aggression:
         a) Creating crisis situations
         b) Escalation
         c) Short term vs. Long term effects
      2) Lack of social validity
         a) Punishment as a barrier to inclusion
         b) Consent and collaboration
      3) Concerns for recovery after punishment
      4) Punishment is an after-the-fact procedure
   d. Examples
   e. Conclusion: **Don’t punish** - it is known to produce the opposite effect than the one needed in a reactive strategy

\[ S^A = S^E \]

Aversive stimuli... are establishing operations for aggression...
(Malott, Whaley & Mallott (1977))

2. Ignoring
   a. The universal strategy as taught by Guido Sarducci
   b. The distinction between ignoring and extinction
   c. Definition: Extinction - A procedure in which reinforcement for a previously reinforced response is discontinued
   d. Empirical considerations of extinction as an aversive event
1) Creating crisis situations
2) Escalation
3) Short term vs. Long term effects
e. Concerns:
   1) Ignoring communicative intent
   2) Ignoring attention getting behaviors
   3) Consent and collaboration
   4) Difficulty
f. Examples
g. Conclusions:
   *Don’t ignore when ignoring is extinction. As an aversive it may escalate the situation

\[ S^A = S^E \]

Aversive stimuli and extinction are establishing operations for aggression...
(Malott, Whaley & Mallott (1977))

* Ignoring may be an option when there is little or no likelihood of escalation, the behavior is not for attention, and it unnecessary to react

3. Natural consequences
   a. Definition: Consequences for behavior that would be likely to occur if he person exhibiting the behavior did not have a disability
   b. The rationale for natural consequences
c. Examples
d. History of natural consequences for people who are challenged with learning difficulties
   1) Earliest strategies used by parents and teachers
   2) Escalation of consequences to formal punishment
   3) Escalation of punishment and corresponding exclusion and devaluation
e. Concerns:
   1) People with learning difficulties are not as likely to learn from natural consequences. Among those who are not likely to learn from such events are those with severe and challenging behavior
2) To rely on natural consequences may be to repeat past patterns of failure

3) Natural consequences can lead to further devaluation and exclusion

4) Natural consequences, as aversive events, can lead to escalation and behavioral crises

f. Conclusion: Use very carefully and under very limited circumstances, i.e., when it will not escalate the situation and when it will not lead to further exclusion and devaluation. (Even when used, it is more likely to serve as a palliative to staff rather than as an effective teaching strategy.)
SESSION 3

THE FUNCTIONS OF BEHAVIOR

A. Why do people misbehave? Behavior has meaning

1. How we react should be partially determined by why the person engages in the behavior
   - Communication
   - Expression of frustration
   - Managing anger and stress
   - Increase/decrease sensory stimulation
   - Change immediate environment
   - Great reaction
   - Reaction to loss of loved one
   - Reaction to pain
   - Neurological event
   - Etc., Etc.

2. The common frustrations in our lives!!!!

B. Understanding the phases of behavior escalation

![Possible Phases of Behavior Escalation]

- Setting event phase
  a. May occur hours, days, weeks or even longer before escalation
  b. Change the relationships between everyday antecedents, behaviors, consequences
  c. Examples:

- Precursor phase

![Figure 3](image-url)
a. Early signs the person displays indicating “something is wrong,” and that challenging behavior may be imminent
b. By responding to the precursors, you may prevent the problem
c. Examples:
d. Don’t wait, react early

3. Target behavior phase
   a. Protect
   b. Resolve
c. Live to tell the tale
d. Punishment and extinction can lead to further escalation and increase risks
e. This is not our arena

4. Recovery phase
   a. The task: not to reignite the crisis
   b. Bide our time
c. Stranger in a strange land
SESSION 4

ANTecedent Control STRATEGIES

A. Introductory comments

1. Definition: Antecedent control strategies involve the removal or elimination of events, objects, or situations that may set off, cue or set the stage for the occurrence of behavior problems or present or otherwise arrange for events, objects, or situations that may decrease the occurrence of those problems

2. The best emergency management method is "NOT" to have an emergency in the first place

B. Remove seductive objects

1. The principle

2. Some examples:
   - Locking the gates so that Ted won’t “elope”
   - Locking up valuables because Sandra has a tendency to take things that don’t belong to her
   - Not sending Paula to the store when she is known to be destructive in that setting
   - Not taking Alan to the store since he is known to grab anything edible and eat it
   - Not giving Ralph small coins since he is known to put them in his mouth
   - Not giving Michael small coins because he will refuse to participate in all activities from that time on

C. Re-deploy/relocate people

   - People who don’t like the client
   - People who do like the client
   - The closer I get to you
   - Behavioral contagion
   - People who take it personally
   - People who don’t take it personally
   - Assertive/demanding personality
   - The military approach
   - Counseling or understanding approach
   - Gentle approach
D. Remove unnecessary demands/requests
   • Turns over the kitchen table when asked to “set the table.”
   • Yells and screams when asked to take out the trash
   • Self injury when asked to do a puzzle
   • Zero demand environment
     — Shape participation
     — Make it too easy

E. Eliminate provocative statements and actions
   • Finger, finger, throw - when criticized
   • Profanity when criticized
   • Disrespectful interactions
   • You have just lost all of your privileges
   • You must do this now
   • Hands on leads to assault
   • Showing signs of fear

F. Change the location and time of activities
   • Slow to awaken
     — Awaken gradually with music
     — Schedule events later in the morning
   • Tantrums when bathed in the bathroom
     — Bathe in the kitchen
   • PE In the afternoon/not first period
   • Don’t interrupt on-going activity (respect)
   • Don’t ask to clean room while watching favorite tv program
   • Change appointment/schedule

G. Rearrange the environment
   • Reposition the furniture
   • Rearrange the pictures on the wall

H. Introduce antecedents for the absence of the behavior
   • People who like the individual
   • Favorite person
• People who don’t take it personally
• Respectful and dignifying interactions
• Ask and suggest rather than demand
• Favorite objects (e.g., toys, ice cream, doll)
• Gentle music to wake up
• Schedule later in the day

I. Stimulus satiation

1. Definition: The continuous and noncontingent availability of the identified reinforcer maintaining the undesired behavior, thereby weakening its reinforcing effects and reducing the rate of the target behavior

2. Examples

**Self-injury for Attention**

![Diagram](image)

- Self-injury: Engages in self-injury every 15 minutes. Function is to have a conversation.
- Attention Interaction: Conversation scheduled every 10 to 12 minutes.

**AWOL**


**Assault to get labels**

- Function: Collection of labels.
REACTIVE STRATEGIES

A. Definition: Reactive strategies are designed to reduce or minimize the episodic severity of behavior

PERSON CENTERED BEHAVIORAL SUPPORTS

**Behavioral Assessment**

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**Multielement Support Plan**

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**Mediation**

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**Outcomes**

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<th>Durability of Effects</th>
<th>Generalization of Effects</th>
<th>Side Effects</th>
<th>Social Validity</th>
<th>Educational/ Clinical Validity</th>
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**Over Time**

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B. Interrupt the behavioral chain

C. Facilitative strategies
   
   1. Active listening
   
   2. Facilitate communication in other ways
   
   3. Facilitate relaxation
   
   4. Help solve the problem

D. Redirection and instructional control
   
   1. Redirection to competing activities
   
   2. Prepotent instructions
   
   3. “Help me” instructions
   
   4. Positive program reminders
   
   5. Self monitoring instructions
   
   6. Redirect to conditions where the behavior is appropriate

E. Proximity control
   
   1. Closeness may influence behavior
   
   2. Examples
F. Introduce humor

1. Humor may interfere with emotions such as anger/anxiety
2. Possible release of endorphins
3. Under used strategy
4. Key words
5. A look or gesture
6. Tickling

G. Stimulus change

1. Definition: the noncontingent presentation of a stimulus or sudden alteration of the incidental stimulus conditions that already exist in the situation, which results in a temporary cessation of ongoing behavior
2. Doing the unexpected
3. Example stimulus change strategies
   - Tantrum
   - Stare into air/swat flies
   - Fall/faint
   - Sing and dance
   - Talk to unseen person
   - I forgot my ________
   - Hold this for me
   - Look at ______
   - Somersault
   - Dropped my contact
   - Act like a chicken
   - Is that a fire engine?
   - Disney mask
   - Drop all your change
   - Break a dish
   - Knock over something
   - Salute
   - Spin like a top
   - Skip/run through the house
   - Talk to yourself
   - Feign a heart attack
   - Coughing attack
   - Stolen surfboard
4. Guidelines for stimulus change:
   - Dramatic changes
   - Short-lived effect
   - Possible problems with repeated presentation
   - Naturally occurring opportunities or “how to enjoy the honeymoon.”
   - Planned novelty
H. Antecedent control strategy

- All of the reactive strategies discussed above, when used in response to precursor behavior, may act as an antecedent control strategy by preventing the occurrence or escalation of the target behavior

**Geographical Containment/Interpositioning**

A. Definition: The use of the immediate environment to minimize or the eliminate the consequences of aggressive or destructive behavior; in other words, to eliminate the need for physical contact

B. Examples:

- Get behind a table
- Circling around furniture
- Stand behind a tree
- Clutter the environment
- Etc.

C. Guidelines:

1. Evasive strategy
2. Accompanied by instructional/facilitative methods

**Emergency Physical Containment**

A. Is emergency physical intervention necessary?

B. Reasons for minimizing the use of emergency physical methods

C. Review
SESSION 6

COUNTER-INTUITIVE STRATEGIES

A. Definition: strategies that run counter to common sense, common wisdom and what many of us believe is appropriate in a support plan for somebody who has severe and challenging behavior

B. Introduce and Maintain a High Level of Time-Based Delivery of Preferred Events

1. Introductory comments about this strategy
   a. This strategy includes both intuitive and counter-intuitive elements
   b. Conceptual example from parenting - child stays home from school

2. Rationale for this strategy
   a. Density of preferred events as a setting event
   b. Withdrawal of a preferred event as an antecedent even
   c. Contrast:
      1) In density of preferred events when compared with others
      2) In contingency of preferred events when compared with others
   d. The implications of noncontingency for avoiding a counter-therapeutic effect
   e. The prime objective

3. Case Study Example

C. Diversion to a Preferred Activity or Event

1. Introductory comments about this strategy
   a. This strategy includes both intuitive and counter-intuitive elements
   b. Conceptual example

2. Rationale:
   a. Stimulus change
   b. Competing reinforcers
   c. Noncontingency/stimulus satiation/reinforcement density
   d. Early response

3. Case Study Example - Massage
D. Diversion to a Perseverative/Compulsive Behavior

1. Introductory comments about this strategy
   a. This strategy includes both intuitive and counter-intuitive elements
   b. Conceptual example (lint)

2. Rationale:
   a. Stimulus change
   b. Competing reinforcers
   c. Noncontingency/stimulus satiation/reinforcement density
   d. Early response

3. Case Study Example - classroom student

E. Strategic Capitulation

1. Definition: Giving the person what is wanted or is being demanded through the behavior

2. Introductory comments about this strategy
   a. This strategy includes both intuitive and counter-intuitive elements
   b. Conceptual examples
      1) Escape/avoidance
      2) Approach/acquisition
   c. Rationale
      1) The logic of behavioral meaning
      2) Noncontingency
      3) Stimulus satiation
      4) Reinforcement density
      5) Losing the battle but winning the war
      6) Early response as a shaping strategy
   d. Case Study - Leave me alone!
   e. Guidelines for using Strategic Capitulation as an emergency management strategy:
      1) Use early
      2) Provide free access to reinforcers
      3) Have fully developed proactive plan which, among other things, is aimed at:
- Improving the person’s overall quality of life
- Giving the person more control over her or his life
- Teaching the person how to communicate
- Teaching the person how to cope
- Reducing the need for any reactive strategies by using focused support strategies

4) Design an adequate and accurate data system to measure effects on both target behavior and relevant collateral behavior

5) Address social validity issues

**Social Validity Issues**

A. Resistance to our approach to Reactive/Emergency Strategies and their sources

B. Procedural needs and the need for reactive strategies

C. Sources of Resistance:
   1. Anti Behavioral Technology
   2. Pro Punishment
      a. Philosophical – Social Role Valorization and the Concept of Culturally Valued Means vs Culturally Normative Means
      b. Emotional
      c. Cultural – Entrenched Practices
         1) Societal
         2) Agency
      d. Personal Beliefs
      e. Institutional Rules and Regulations
         1) Zero Tolerance
         2) Suspensions
         3) Assertive Discipline
      f. Logical/Judgmental
      g. Professional Practice Routed in Linear Approaches
         i. Empirical Research Routed in Linear Approaches

D. Critical strategies for increasing the acceptance of this approach

   1. Establishing an explicit agreement as to the desired outcomes and maintaining a focus on these
2. Comprehensive Functional Assessment - creating an understanding of the meaning and legitimacy of the behavior

3. Obtaining consent and collaboration from parents, staff and other affected people

4. Establishing the multielement rationale and context for the recommendations

5. Distinguishing between long-term vs short-term goals

6. Negotiation

7. Monitoring and evaluation

8. Community considerations

9. Have staff and parents develop their own individual plan for emotional management

E. The payoff...


Module 4: Assuring Staff Consistency and the Provision of Quality Services Through the Application of Organizational Behavior Management

An Introduction to an Effective Quality Improvement and Outcome Evaluation System based on the book The Periodic Service Review: A Total Quality Assurance System for Human Services and Education

Gary W. LaVigna, Ph.D., BCBA-D
SESSION 1

THE PERIODIC SERVICE REVIEW

I. Introduction

A. Typical Performance Problems
   - Inconsistent data
   - Forget to run the program
   - Lack of active programming
   - Not doing anything
   - Don’t treat clients with respect
   - Don’t carry out programs as designed
   - Don’t follow the schedule
   - Negative staff/client interactions
   - Objectives poorly written
   - Supervisors don’t supervise
   - No training

B. Explanations for Performance Problems
   - Poorly motivated staff
   - Poor wages
   - Lack of training
   - Don’t believe it will work
   - Not enough time in the day
   - Don’t like the clients
   - Lazy
   - Lack intelligence to understand program
   - Raining, snowing, bus broke down, no money
   - Not enough staff
   - Supervisors don’t know what they are doing

II. Background Information

A. Lack of management training

B. Need for management training
   1. Direct care staff often lack formal training
   2. Difficult task/limited resources

C. Effective staff management
   1. Defining performance responsibilities
   2. Monitoring performance
   3. Teaching skills to staff
   4. Changing performance

D. Research Gaps
   1. Limited Scope
      a. Small number of staff performance areas
      b. Small amount of time
2. Lack of maintenance studies

E. The Periodic Service Review

III. The Periodic Service Review

A. History

B. Group Home Consultation

C. STEP Management

D. Systems Change

E. Key Elements

1. Performance Standards

2. Performance Monitoring

3. Performance Feedback

4. Staff Training
SESSION 2

PERFORMANCE STANDARDS

IV. Performance Standards

A. Definition: The specification and operationalized definition of staff responsibilities

B. Rationale: Provides basis for training, monitoring, performance evaluation, and management and supervisory action.

C. Process vs. Product or Outcome Standards

1. Definitions

2. Examples

3. Outcome Evaluation

D. Categories Generated By:

1. Client goals and objectives

2. Administrative requirements

3. External Agencies

E. Basic Principles

1. Emphasis on essentials
   a. Critical elements
   b. Response chains
   c. Response classes
   d. Multi-level

2. Realistic
   a. Average past performance
   b. Best past performance
   c. Performance objectives

3. Explicit criteria
   a. Operational definition
   b. Time-lines

4. Verifiable
   a. Permanent Product
   b. Direct Observation
V. Performance Monitoring

A. Definition: Ongoing verification that staff responsibilities have been carried out.

B. Rationale: For internal accountability and set the stage for management and supervisory action.

C. Staff Acceptance

1. Issues
   a. New vs. old staff
   b. Monitoring history

2. Increasing acceptance
   a. Positive payoffs
      1) Focus on visibility
      2) Focus on success
      3) Focus on opportunity
   b. Staff participation
      1) Setting standards
      2) Consensus monitoring
      3) Setting objectives
   c. Shared responsibility
   d. Initial self-monitoring
   e. Emphasis on professionalism
   f. Staff commentary

D. Basic principles

1. Sampling
2. Regular schedule
3. Proactive schedule
4. Reliability (Consensus)
5. Validity (Performance Standards)
6. Quantified, summarized, and analyzed
7. Sets occasion for management and supervisory action
VI. Performance Feedback

A. Definition: Management and supervisory action based on results of performance monitoring.

B. Rationale: To improve and maintain staff performance

C. Results of traditional feedback:
   1. Elicited Aggression
   2. Resistance
   3. Escape
   4. Low Morale

D. Basic principles
   1. Visual feedback
      a. Posted
      b. Noncompetitive
      c. Anonymous
      d. Multi-level
   2. Positive reinforcement
   3. Clarification/Training
   4. Mutual and realistic goals

E. Extrinsic consequences
   1. Cost implications
   2. Job satisfaction and performance

F. Corrective Action
   1. System Focus
      a. Structure
      b. Revised Training
      c. Additional Resources
   2. Person Focus
   3. Failure
SESSION 4

STAFF TRAINING

VII. Staff Training

A. Definition: Instruction to establish staff competence to perform responsibilities.

B. Rationale: For them to perform their responsibilities

C. Not Awareness Training

D. Competency based; criterion referenced
   1. General
   2. Specific
      a. Verbal Competence
         1) Read and review each item on PS/TA
         2) Explained by supervisor
         3) Questions answered
         4) Competency Test
      b. Analog Competence
      c. In-Vivo Competence

E. Limitations

VIII. Outcome Evaluation

A. Definition: The measure of an agency’s success in meeting its goals and objectives.

B. Rationale
   1. Management
   2. Accountability

C. Basic Principles
   1. Process Evaluation
   2. Product Evaluation
      a. Objectives met
      b. Placement/Enrollment
      c. Satisfaction ratings
   3. Third Party Evaluation

IX. Variations

A. Staff focus
B. Client focus

C. Sharp shooting

X. Getting Started

A. Identify Service Unit
   1. Develop Draft Standards
   2. Shared Responsibility
   3. Process and Outcome

B. Meet with Staff
   1. PSR Inservice
   2. Introduce PSR Draft
   3. Produce Consensus Standards

C. Schedule Self Monitoring Period

D. Initiate Monitoring and Feedback

E. Review and Evaluate PSR

F. Expand PSR

G. Resolve Barriers

H. Call
Sample Periodic Service Reviews
IABA® PSR Session Protocol

1. Initial Implementation Date:

2. Dates Revised:

3. Step by step method:
   a. A trained member of the team should facilitate the scoring of the PSR score sheet with at least one other or, if possible, more representatives of the team present. That is, there should be at least one direct service staff (if position is presently filled) and one other member of the team present at the PSR session, in addition to the facilitator.
   b. A PSR session is not carried out in a top-down review, i.e., are you doing what you need to do, but rather in the spirit of a team holding itself accountable, i.e., are we doing what we said we wanted to do. Hence:
      1) The facilitator does not have to be a member of the management team.
      2) The tone and words used should be in the Team spirit not the top-down spirit.
   c. The following are the materials that should be present and available before a PSR session begins:
      1) The relevant PSR score sheet.
      2) The Operational definitions for each item on the score sheet.
      3) All permanent records or products needed to score the PSR score sheet. If the PSR session is taking place in the field, this means special care in making sure the necessary “Office” records are available and if the session is taking place in the office, this means special care in making sure the “field” records are available.
      4) The relevant PSR graphs.
      5) A listing and description of the Service Units that comprise the relevant department (not applicable for STEP).
      6) A roster of the total team assigned to the relevant Service Unit, including the assigned members from the management team, consultants, etc. The team should not be comprised exclusively of direct service staff.
      7) A written statement that indicates how Service Units and/or consumers are to be randomly selected for PSR review.
   d. The representatives of the team being reviewed and the consumer selected should be indicated on the PSR score sheet and should have been selected in accordance with the random selection procedure described in “c. – 7” above. The facilitator’s initials next to the selected consumer’s name will indicate that the random selection procedure was followed.
   e. All items scored on the PSR should be done so based on permanent products records, including those items that require a spot check review or direct observations. For the later, those spot check reviews and/or direct observations should have taken place at a separately scheduled time, with the results documented in a permanent record to be used for the PSR review. The only exceptions to this may be those spot check reviews and direct observations that can be carried out in such a way that the PSR session itself, including the spot checks and direct observations, last no more than 30-minutes.
   f. The actual documentation should always be visually reviewed. The team should not rely on memory to score any item.
   g. The items on the PSR score sheet and the operational definitions should be so clear as to lead to an easy consensus among the team members present as to whether or not a standard was met. If there is not an immediate consensus, the documentation and the operational definition should be reviewed to see if the appropriate scoring can be clarified and a consensus reached. If there is no consensus, the standard should be scored as unmet with an asterisk indicating the lack of consensus. (The item and copies of the documentation should be referred to the Director for clarification. In such cases, the operational definition will almost certainly need to be rewritten to eliminate the ambiguity that exists. This may lead to a service-wide revision of the PSR.)
   h. The facilitator should model positive reactions to unmet standards. One way to do this is to be positive about having the information necessary to work together to improve services. If any member of the team makes a negative statement, the facilitator should, after listening actively, take some time to help that person re-frame their reaction in positive terms. This requires attention to both the spirit and content of what is being said.
   i. Team members should be invited to make comments on the score sheet to explain the reasons for an unmet standard, if they choose to do so.
   j. After the PSR score sheet has been completed, the facilitator should calculate the PSR percentage score and bring the PSR graph up-to-date. The graph should then be visually displayed to all present team members.
   k. The facilitator should make only positive comments about the results, regardless of what they are. This might be accomplished by making positive comments about the visibility the team has about where it is, which is much better than not knowing; by commenting on the specific standards that are being met, especially those that might be recent accomplishments; and by characterizing unmet standards not as deficiencies, deficits or problems (bad things) but opportunities to improve the quality of services (good things). Remember to use both a positive tone and spirit as well as positive words.
1. If staff make negative statements after or while viewing the PSR graph, the facilitator should help them re-frame their reactions in positive terms, as described above.

m. The facilitator should then pose the question: “What opportunities should we take advantage of between now and our next PSR session?”

n. A list of tasks, person responsible and target dates should be developed.

o. Members of the team not present at the PSR session, whose names are included on the team roster may be assigned by consensus with responsibility for a task.

p. This process of taking advantage of opportunities should also be done in the Team rather than the top-down spirit.

q. The facilitator should then use the channels that have been set up to assure that every member of the Team sees that updated graph within one working day. Upon review, each team member should initial and the graph.

r. Supplemental responsibilities should be recorded on the task list by and distributed to everyone on the team as determined by the facilitator.

s. The completed PSR score sheet should be filed in the relevant PSR notebook or other agreed upon place within one working day.

4. Procedural reliability checks of the implementation of this protocol should be carried out quarterly for each facilitator. However, if the reliability score is below 90%, checks should be carried out weekly until 90% or above is achieved for 3 consecutive sessions. The results of these procedural reliability checks should be filed.

5. Observational reliability should be assessed as called for on the Management PSR for the service.

6. Fail Criteria: Inability of any facilitator to meet procedural criteria at 90% level for two or more procedural reliability checks in a row. This failure should be an indicator that the procedural steps may need to be clarified with revised descriptions. Such revisions should be developed and adopted by all services within three months of meeting the fail criteria or a written explanation should be provided by the Directors.

7. Pass Criteria: The fail criteria has not been met. If the fail criteria has not been met, this protocol should be kept in use.

8. Variations to these protocol requirements because an item does not apply should be documented and explained on the appropriate PSR Variations Form.

Protocol prepared by: Ayndrea LaVigna

Approved by: Gary W. LaVigna, Jan. 21, 2000
Periodic Service Review
John Smith

Revised March 31, 1999

PSR Review date:_________________________________________________________________________________________________
Facilitator: ______________________________________________________________________________________________________
Participants: _____________________________________________________________________________________________________
________________________________________________________________________________________________________________
________________________________________________________________________________________________________________

+/0

1. Periodic Service Review (PSR):
   a. Implementation: A “+” is scored if PSR graph shows at least two data points for previous 30 days.
   b. Progress: A “+” is scored if PSR graph shows current status of at least 85% or best score ever was achieved within previous 30 days.

2. Data Collection:
   a. Data Collection: A “+” is scored if Data file has fully filled out ABC Sheet for each occurrence of High Risk Behavior or identified precursor behaviors which occurred during previous 30 day period. (See original recommendations).
   b. Monthly Reliability Report: A “+” is scored if Reliability file has formal reliability report for prior month and concludes confirms that all incidents of High Risk Behavior and identified precursor behaviors have been recorded and summarized.
   c. Summary Graphs: A “+” is scored if summary graphs of HRB and identified precursors are up to date.

3. Ecological Strategies:
   a. Complaint Opportunities. A “+” is scored if the minutes of the last Team Meetings indicates that Mr. Smith solicited John’s concerns and questions and reported them to the group.
   b. Recruitment Criteria. A “+” is scored if a list is available in the Rainbow Book which has been countersigned by Mrs. Smith indicating the desired characteristics of staff recruited to work with John. The list needs to be dated within the year.
   c. Staff Induction Phases. A “+” is scored if the Induction Roster that all staff working with John have gone through all three induction phases within 30 days of assignment or as otherwise explicitly scheduled.
   d. Written Daily Schedule. A “+” is scored if there are written daily schedules completely filled out for previous week using agreed upon format indicating John’s involvement in the process.
   e. Full School Day. A “+” is scored if there is an approved and current IEP in the file aimed at John’s achieving a high school degree and providing for a full six-hour school day.
   f. Formal Individualized Transition Plan. A “+” is scored if there is an approved and current ITP in the file.
   g. Alarms. A “+” is scored if alarms have been installed in the house to alert the family if John should leave during the night.
   h. Team Solidarity. A “+” is scored if the minutes of the last team meeting shows that there is a consensus that the spirit of solidarity is being respected.
   i. Questions, Concerns and Decisions. A “+” is scored if the minutes of the last team meeting shows that there is a consensus that questions, concerns and decisions are presented with a unified front with respect to John.
   j. Mary Jones. A “+” is scored if the minutes of the last team meeting indicates that Mary Jones is still available to mediate any team issues if necessary.
   k. Vacation. A “+” is scored if the minutes of the team meeting reflect that Mrs. Smith has taken a vacation of at least one week in the previous year to enhance John’s independence.
   l. Peer Interactions. A “+” is scored if there is a plan of activities for the current month in the file and it reflects completion prior to the start of the month and John’s involvement.

4. Positive Programming:
   a. General Skills:
      1) Meal Preparation. A “+” is scored if the last scheduled training session has been carried out and training data were collected and summarized.
2) **Shopping.** A “+” is scored if the last scheduled training session has been carried out and training data were collected and summarized.

3) **Vocational Skills.** A “+” is scored if the last scheduled training session has been carried out and training data were collected and summarized.

4) **Math.** A “+” is scored if there is a list of math skills provided in the files which indicates which skills John needs to master to pass her proficiency test and that at least one new skill was mastered in previous month.

5) **Recreational/Social Skills.** A “+” is scored if the last scheduled training session has been carried out and training data were collected and summarized.

b. **Functionally Equivalent Skills - Picture Arrangement.** A “+” is scored if the last scheduled training session has been carried out and training data were collected and summarized.

c. **Functionally Related Skills - Critical Social Skills.** A “+” is scored if the last scheduled training session has been carried out and training data were collected and summarized.

d. **Coping and Tolerance Skills.** A “+” is scored if the last scheduled training session has been carried out and training data were collected and summarized.

5. **Focused Support:**
   a. **Progressive Token System (DROP).** A “+” is scored if the minutes of the last team meeting reflect a report from Mr. Smith that the system is still in place and is being kept current.
   b. **Distraction Menu.** A “+” is scored if there is a Distraction in the file, it has Mrs. Smith’s signature on it and it is dated within the prior three months.

6. **Reactive Strategies.**
   a. **Scripts.** A “+” is scored if there are scripts in the file indicating how staff are to respond to HRB and Identified Precursor Behavior and they are dated within the prior three months.
   b. **HRB Prevention Analysis Reports (PAR).** A “+” is scored if a formal PAR has been filed for each occurrence of HRB or an Identified Precursor behavior during the previous 30 days.

7. **Staff Development and Management Systems.**
   a. **Competency Based Training.** A “+” is scored if a Competency Based Training Program has been developed for staff induction, a completion schedule has been established in the Team Minutes and all direct service staff have completed program or are on schedule.
   b. **Introductory Stories.** A “+” is scored if an introductory story to introduce John to staff is available in the files, it is dated within three months and there is a list showing that all current staff have read the story.
   c. **Protocols.** A “+” is scored if there is an active protocol for all items listed on the active protocol list following the agreed upon format. (Prorated credit is provided, e.g., 5/12=.42)
   d. **Three Tiered Training.** A “+” is scored if staff training records indicate they have been trained to the third tier for each of the protocols. (Prorated credit is provided.)
   e. **Procedural Reliability Checks.** A “+” is scored if Checks have been carried out for all active protocols as scheduled for prior month and agreed upon standard has been met. (Prorated credit is provided.)
   f. **Team Meetings.**
      1) **Clinical.** A “+” is scored if last scheduled meeting was held and minutes show standard agenda was followed.
      2) **Team.** A “+” is scored if last scheduled meeting was held and minutes show standard agenda was followed.
   g. **Coordinator.** A “+” is scored if Team minutes from most previous meeting reflect name of Team coordinator and that he/she attended meeting.

8. **Quarterly Review and Progress Report.** A “+” is scored if last quarterly progress report follows standard format and is dated within prior four months.

Score Achieved
Score Possible
Percentage of Score Achieved to Score Possible
Appendix I.

PERIODIC SERVICE REVIEW AND INDIVIDUAL PERFORMANCE STANDARDS FOR A BEHAVIOR SERVICES UNIT SCORING SHEET

PERIODIC SERVICE REVIEW FOR A BEHAVIOR SERVICES UNIT:

Score Sheet

Date of Evaluation: ____________________________________________

Evaluator: ___________________________________________________

Responsibilities

<table>
<thead>
<tr>
<th>Responsibilities</th>
<th>ACHIEVED</th>
<th>POSSIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Administrative and General</td>
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<tr>
<td>A. Job Performance Standards</td>
<td></td>
<td></td>
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<tr>
<td>1. Monthly Individual Reviews</td>
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<tr>
<td>2. 85% Performance Level</td>
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<tr>
<td>B. Client Case Files</td>
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<tr>
<td>1. De-institutionalization Candidates</td>
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<td></td>
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<tr>
<td>2. Community Cases Case load</td>
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<td>C. Periodic Service Reviews</td>
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<tr>
<td>II. De-institutionalization Project</td>
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<td>A. Community Integration</td>
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<td>1. Initial Placement</td>
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<td>2. Maintenance</td>
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<td>B. Assessment and Intervention Plan</td>
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<td>1. Complete</td>
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<td>2. Timely</td>
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<td>C. Approval of Intervention Plan</td>
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<tr>
<td>1. Individualized Program Plan (IPP)</td>
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<td>2. Program Review Committee (PRC)</td>
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D. Key Social Agent (KSA) Procedural Reliability

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<th>Possible</th>
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E. Communication

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<th>State Hospital Meetings</th>
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F. Reports

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<td>a. Complete</td>
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<td>b. Timely</td>
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<tr>
<td>c. Submitted and Filed</td>
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<tr>
<td>2. Termination Reports</td>
<td></td>
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<tr>
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<td>b. Timely</td>
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<td>c. Submitted and Filed</td>
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<tr>
<td>3. Follow-Up Reports</td>
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G. Database

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<td>2. Ongoing Data</td>
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<td>3. Quality of Life</td>
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III. Intensive Intervention

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<tr>
<td>2. Maintained</td>
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</table>
D. Communication
1. Weekly Meetings
2. Provider Evaluations

E. Fading
1. Target Date
2. Fading Process

F. Provider Periodic Service Review
1. Developed
2. Staff Responsible
3. Maintained

IV. Community Behavior Services

A. Referrals
1. Logged
2. Initial Information Gathered
3. State Hospital Deflection
4. Advisory Committee Review
5. Assignment

B. Assessment and Intervention Plan
1. Completed
2. Timely

C. Intervention Plan Approval
1. IPP
2. PRC

D. KSA Procedural Reliability
1. Achieved
2. Maintained
### E. Reports

1. Quarterly  
   a. Complete  
   b. Timely  
   c. Submitted and Filed

2. Termination Reports  
   a. Complete  
   b. Timely  
   c. Submitted and Filed

3. Follow-Up Reports

### F. KSA Evaluations

### G. Database

1. Baseline Data
2. Ongoing Data
3. Quality of Life

### H. Consent for Treatment

### I. Intervention Agreement

### J. Periodic Service Review

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<th>POSSIBLE</th>
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Total score possible

Total score achieved

Percentage score

**Comments/Issues/Recommendations:**
PERIODIC SERVICE REVIEW FOR A BEHAVIORAL SERVICES UNIT:

Operational Definitions

I. Administrative and General

A. Job Performance Standards

1. Each staff member is evaluated monthly on individual performance standards, as documented by individual performance graphs.

2. Each staff member maintains performance levels of 85% or better.

B. Client Case Files. Files in unit office are neat, organized, updated, and include everything on standard table of contents. Follow model case file. Evaluation is based on a random sample of three people each month from each of the following categories.

1. De-institutionalization candidates

2. Community case load

C. Periodic Service Reviews. Service programs are maintained at the average 85% level or better, as measured by their own periodic service review, based on summary graph of all services. If not established through intensive intervention, service meetings are tracked on separate graphs for the first 6 months of behavior services unit participation.

II. De-institutionalization Project

A. Community Integration

1. Initial Placement. De-institutionalization candidates are placed in community settings and programs, as determined by comparing formal project placement schedule with updated list of current placement for all identified clients. Score + if all candidates who should have been placed were by the target date and an o if not.

2. Maintenance. All people placed in the community are being maintained in initial placement or other community placement identified as less restrictive or more appropriate. Score o if person was or is back in a state hospital or in another psychiatric hospital, as determined by review of updated list of current placements.

B. Assessment and Intervention Plan

1. Complete. Assessment reports and intervention plans satisfy the behavior services unit format and content requirements, as documented by an 85% score or better on the behavior services unit evaluation review for all de-institutionalization candidates.

2. Timely. Assessment reports and intervention plans for de-institutionalization candidates are complete and available for formal staffing prior to placement, based on review of report date and date on staffing meeting minutes. Score based on reports due that month. Reports due for previous months must also be complete to receive a +.

C. Approval of Intervention Plan

1. The complete proposed intervention plan along with draft protocols is reviewed, modified (if applicable), and approved by the persons individualized program plan (IPP) team prior to implementing the plan. Score based on comparison of date on IPP, which includes the intervention plan with the date of implementation of the plan.

2. If applicable, the intervention plan and protocols approved by the IPP team are reviewed and approved by the program review committee (PRC) prior to implementing the plan. Make any needed changes based on PRC recommendations within 1 week of the PRC meeting. Submit final plans and protocols to the case manager, state hospital, and the provider, and file in the client’s file. Score based on comparison of the date on the PRC approval form with the date of implementation of the plan.

D. Key Social Agent (KSA) Procedural Reliability

1. Achieved. KSAs achieve 90% procedural reliability on all elements of intervention plan within 30 days of placement for those individuals who do not receive intensive intervention services, or within 30 days of transition from intensive intervention. This is based on formal procedural reliability checklist. Plans that should have been fully implemented during the previous month should also have achieved 90% on procedural reliability scores to receive a +.

2. Maintained. KSAs maintain an 85% or better procedural reliability score for all program elements as determined by monthly procedural reliability checks for each element as documented on control sheet.

E. Communication

1. State Hospital Meetings. Monthly meeting held between behavior services unit management team and state hospital representative for the purpose of updating state hospital on the status of project and individual candidates as documented by formal meeting minutes showing that meeting protocol was followed.

2. Provider Meetings. Weekly meetings are held by the behavior services unit supervisor with each provider, represented by both management and direct care staff, as documented by formal meeting minutes showing that meeting protocol was followed. Upper management of provider agency will be included in these meetings monthly for the first quarter of placement and quarterly thereafter.
3. Provider Evaluations. These are completed monthly by the immediate supervisor at the provider agency. Score + if 3s or better on all items and no complaints to the behavior services unit since the last PSR evaluation.

F. Reports

1. Quarterly Progress Reports
   a. Complete. Quarterly progress reports satisfy behavior services unit format and content requirements, as documented by 85% score or better on behavior services unit evaluation review for all deinstitutionalization case load based on last scheduled reports.
   b. Timely. Quarterly progress reports are submitted for typing within 2 weeks of end of service quarter.
   c. Submitted and Filed. Final versions of quarterly progress reports are typed, submitted, and filed within 30 days of end of service quarter. Submission should be to state hospital, service providers, and case managers in addition to submission to the behavior services unit supervisor.

2. Termination Reports
   a. Complete. Termination reports satisfy behavior services unit format and content requirements, as documented by 85% score or better on behavior services unit evaluation review for all deinstitutionalization case load.
   b. Timely. Termination reports are submitted for typing or editing within 2 weeks of the termination date.
   c. Submitted and Filed. Final versions of termination reports are typed, submitted, and filed within 30 days of the termination date. Submission should be to state hospital, service providers, and case managers in addition to the behavior services unit supervisor.

3. Follow-Up Reports. Follow-up reports are completed within 30 days, 6 months, 12 months, and 18 months following termination date in accordance with the behavior services unit follow-up protocols. Score + if report is complete and is filed in all applicable client files.

G. Database

1. Baseline Data. One full week of baseline data on all targeted behaviors are collected and summarized on a graph prior to placement when feasible, but no longer than within 1 week of placement. Formal interobserver reliability checks are to be conducted for each target behavior showing 85% reliability or better. Score based on all candidates placed in current month.

2. Ongoing Data. Ongoing data are maintained for all targeted problems with at least one formal reliability check each month per target behavior with reliability at 85% or better as documented on data-tracking chart.

3. Quality of Life. Quality of life indicators are tracked based on recording of:
   a. Number of environments (off grounds of the residence) obtained by the individual daily
   b. Number of hours spent in different community settings (not counting day program) daily
   c. Number of people the individual has interactions with daily who are neither disabled nor paid to interact with him or her
   d. Daily mood ratings documented at weekly team meetings
   e. Weekly dollars earned

   Specific quality of life measures are established for each individual in the program setting Periodic Service Reviews. Score quality of life database + if individual data have been maintained completely for the month.

III. Intensive Intervention

A. Consent for Treatment. All items on the informed consent checklist are discussed by the behavior specialist with the individual, responsible person, and key social agents. Agreement is reached on each item and signatures are obtained prior to initiation of intensive intervention services. The consent form is maintained in the client's master record. This item is scored by a comparison of the signature dates on the consent form with the date intensive intervention services began for all cases initiated for the month.

B. Intensive Intervention Agreement. The intensive intervention agreement is reviewed and signed by the director of the provider agency (or KSA if appropriate) and the behavior services unit manager prior to initiation of intensive intervention services. The agreement is maintained in the behavior services unit individual master record. This item is scored by a comparison of the signature dates on the agreement with the date intensive intervention services began for all cases initiated for the month.

C. Procedural Reliability

1. Achieved. Intensive intervention staff achieve 90% procedural reliability within 7 days of program implementation based on a formal reliability check. A + is given if the plans that have been implemented during the previous month reveal scores of 90% or better on procedural reliability checks performed for responsible staff.

2. Maintained. Intensive intervention staff maintain 90% procedural reliability based on a formal reliability check conducted monthly.
IV. Community Behavior Services

A. Referrals

1. Logged. All new referrals are logged within 1 working day of receiving the referral. Score + if all known referrals are documented in the log, 0 if a known referral has not been logged.

2. Initial information Gathered. The referral information form is completed based on initial information from appropriate KSA within 1 week of receipt of the referral. Score by comparing date of referral in log with date on referral information form.

3. State Hospital Deflection. Those individuals currently living in the community who previously resided at the state hospital within the past 3 years are considered a part of the de-institutionalization project. These people will be given priority for behavior services unit service if they are at risk for return to state hospital. The names of these people will be recorded and maintained in the referral file.

4. Advisory Committee Review. The committee will meet every 2 weeks to review and prioritize community referrals for the behavior services unit. Decisions made by the committee will be kept in meeting minutes that will be filed in the behavior services unit referral file. The committee will only provide disposition for as many referrals as time is available. In the event that the behavior services unit determines that it is unable to initiate new services due to present case load, regular committee meetings will be suspended until time is available.

5. Assignment. Assignment of cases from the advisory committee is made within 2 working days to an available behavior specialist, as evidenced by the date of initiation of an intervention activities checklist on the case.

B. Assessment and Intervention Plan

1. Completed. Comprehensive behavior assessments and intervention plans will be developed using the standard behavior services unit format, as evidenced by an 85% or better on the behavior services unit assessment checklist on one random service recipient per month.

2. Timely. Assessment reports and intervention plans will be submitted for typing and/or editing within 30 days of assignment or within timeframes otherwise specified.

C. Intervention Plan Approval

1. IPP. The complete proposed service plan along with draft protocols is reviewed, modified (if applicable) and approved by the individual’s PP team prior to implementing the plan. Score based on comparison of date on PP that includes the intervention plan with the date of implementation of the plan.

2. PRC. If applicable, the intervention plan and protocols approved by the PP team is reviewed and approved by the PRC prior to implementing the plan. Make any needed changes based on PRC recommendations within 1 week of the PRC meeting. Submit final plans and protocols to the case manager, state hospital, and the provider, and file in the case file. Score based on comparison of the date on the PRC approval form with the date of implementation of the plan.

D. KSA Procedural Reliability

1. Achieved. KSAs achieve 90% procedural reliability on all elements of intervention plans within 30 days of program implementation based on formal reliability checks. Plans that should have been fully implemented during the previous month should also have achieved 90% on procedural reliability scores to receive a +.

2. Maintained. KSAs will maintain an 85% or better procedural reliability score for all program elements as determined by monthly procedural reliability checks for each element as documented on control sheet.
E. Reports

1. Quarterly
   a. Complete. Quarterly progress reports satisfy behavior services unit as documented by an 85% score or better on the behavior services unit evaluation review.
   b. Timely. Quarterly progress reports are submitted for typing 2 weeks prior to the end of service quarter as evidenced by an 85% score on the tracking cover sheet.
   c. Submitted and Filed. Final versions of quarterly progress reports are typed, submitted, and filed within 30 days of the end of the service quarter. Submission should be to the case manager, responsible person, and service providers in addition to submission to the behavior services program supervisor.

2. Termination Reports
   a. Complete. Termination reports satisfy behavior services unit format and content requirements as documented by 85% score or better on behavior services unit evaluation review for all behavioral services recipients.
   b. Timely. Termination reports are submitted for typing or editing within 2 weeks of the termination date.
   c. Submitted and Filed. Final versions of termination reports are typed, submitted, and filed within 30 days of the termination date. Submission should be to the responsible person, service providers, and case managers in addition to the behavior services program supervisor.

3. Follow-Up Reports. Follow-up reports are completed within 30 days, 6 months, 12 months, and 18 months following termination date in accordance with the behavior services unit follow-up protocols. Score + if report is complete and is filed in all applicable case files.

F. KSA Evaluations. KSAs will be asked to complete a social validity questionnaire for each individual receiving services monthly for the duration of intervention services from the behavior services unit. Behavior services unit staff will receive a 3 or better on each item on the social validity check.

G. Database

1. Baseline Data. One full week of baseline data on all targeted behaviors are collected and summarized on a graph prior to program implementation. Formal interobserver reliability checks are conducted for each target behavior showing 85% reliability or better. Score based on all individuals placed in current month.

2. Ongoing Data. Ongoing data are maintained for all targeted problems with at least one formal reliability check each month per target behavior with reliability at 85% or better, as documented on data-tracking chart.

3. Quality of Life. Quality of life indicators are tracked based on recording of:
   a. Number of environments (off grounds of the residence) accessed by the person daily
   b. Number of hours spent in different community settings (not counting day program) daily
   c. Number of people the person has interactions with daily who are neither disabled nor paid to interact with him or her
   d. Weekly mood ratings documented at weekly team meetings
   e. Weekly dollars earned

Score quality of life database + if individual data have been maintained completely for the month.

H. Consent for Treatment. All items on the informed consent checklist are discussed by the behavior specialist with the individual, responsible person, and key social agents. Agreement is reached on each item and signatures are obtained prior to initiation of behavior services unit services. The consent form is maintained in the master record. This item is scored by a comparison of the signature dates on the consent form with the date behavior services unit services began for all cases initiated for the month.

I. Behavior Services Intervention Agreement. This is reviewed and signed by the service provider representative (or KSA, if appropriate) and the behavior specialist prior to initiation of intervention services. The agreement is maintained in the case file. This item is scored by a comparison of the signature dates on the agreement with the date intervention services began for all cases initiated for the month.

J. Periodic Service Review. A periodic service review is developed for each site in which services are provided that reflects the service plan. Agency staff are trained to assume responsibility for all items on the PSR, achieve an initial 90% level within 30 days of implementation, and maintain an 85% level or better based on monthly formal PSR checks.
Score Sheet

Name: ____________________________________________________________________________________________________________

Date of Evaluation: _______________________________________________________________________________________________

Evaluator: _______________________________________________________________________________________________________

<table>
<thead>
<tr>
<th>Responsibilities</th>
<th>ACHIEVED</th>
<th>POSSIBLE</th>
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<tbody>
<tr>
<td>I. Meetings</td>
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<tr>
<td>A. Weekly Unit Meetings</td>
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<td>B. Provider Agency Management</td>
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<td>C. Monthly with State Hospital</td>
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<tr>
<td>II. Budget and Contracts</td>
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<tr>
<td>A. Identify Providers and Establish Contracts for Services for De-institutionalization Candidates</td>
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<td>B. Contract for Support Services</td>
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<td>C. Track Expenditures</td>
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<td>D. Process Billings</td>
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<td>III. Supervision</td>
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<td>A. Personnel</td>
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<td>B. Time Sheets</td>
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<td>C. Staff Travel</td>
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<td>D. 1:1 Supervision of Supervisor</td>
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<td>E. Serve as Program Supervisor</td>
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<td>IV. Monitoring</td>
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<td>A. PSR for Program Supervisor</td>
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<td>B. PSR for Behavioral Services Unit</td>
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<tr>
<td>C. Service Providers Summary Graph</td>
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<tr>
<td>D. Monthly Reports to Area Program Manager (APM)</td>
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<td>V. Referral Process</td>
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<td>A. Referral Packets Complete</td>
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<td>B. Call Advisory Committee Meetings</td>
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<td>C. Cancel Advisory Committee Meetings</td>
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<td>D. Assign Cases</td>
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<td>VI. Direct Service</td>
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Total score possible _________________________________________
Total score achieved _________________________________________
Percentage score ___________________________________________

Comments/Issues/Recommendations:
INDIVIDUAL PERFORMANCE STANDARDS

BEHAVIOR SERVICES UNIT MANAGER

Operational Definitions

I. Meetings
A. Conduct weekly unit meetings including the following agenda items:
1. Administrative and informational items
2. Discussion of status of all unit cases
3. Full staffing of one case
4. Presentation of training/professional development topic by one member of the unit staff one meeting per month
   Score + if meeting minutes reflect all agenda items discussed.
B. Meet monthly with the administration of agencies providing service to unit clients to review progress and discuss any problems. Score + if meeting minutes reflect the above discussion.
C. Meet monthly with state hospital staff to provide updated information on planned movement of de-institutionalization candidates and to discuss any problems. Score + if meeting minutes reflect the above discussion.

II. Budget and Contracts
A. Identify providers for de-institutionalization candidates and work with contracts staff to establish contracts or contract amendments. Ensure that residential and day care service plans are finalized at least 30 days prior to each person’s target discharge date. Score + if provider is identified and contract or amendment is in process.
B. Identify providers and contract for support services for the behavior services unit, including management and psychological and psychiatric consultation. Score + if contracts are in place for all needed services.
C. Track expenditures for behavior services unit services and submit an expenditure report to the area program manager within 2 weeks of the end of each month. Score + if date on expenditure report is within 2 weeks of the end of the month.
D. Process billings from consultants within 2 days of receipt of statements at the behavior services unit office. Score by comparing date billing received with date billing forwarded to appropriate person.

III. Supervision
A. Perform personnel-related responsibilities including hiring and possible disciplinary actions for program supervisor within policy and timeliness. All personnel actions are maintained in behavior services unit personnel files. Score + if dates on all personnel paperwork fall within time-lines.
B. Ensure that program supervisor time sheets are completed correctly, sign time-sheets of subordinate staff, and deliver time sheets to the appropriate authority prior to noon on the final day of each pay period.
C. Approve the use of private vehicles or state vehicles for official purposes. Approve travel claims, ensuring the accuracy of all travel claimed. Score + if no travel claims are returned for correction during the month.
D. Provide 1:1 supervision of program supervisor at least 2 hours per week.
E. Serve as program supervisor for those cases in which the unit program supervisor is providing direct services. Score based on achievement of 85%

IV. Monitoring
A. Conduct PSR of program supervisor performance monthly.
B. Conduct PSR for behavior services unit monthly, graph and post results in behavior services unit office within 2 weeks of the end of each month.
C. Graph and post summary graph of service provider PSR scores monthly. Except for those providers who are not receiving intensive intervention services and have provided services to behavior services unit clients for fewer than 6 months — the PSR for these providers will be graphed separately.
D. Provide monthly progress reports to the area program manager within 2 weeks of the end of each month that contain the following information:
   1. Number of individuals served by type of setting
   2. Number of current active cases
   3. Number of follow-up cases
   4. Number of closed cases
   5. Number of referrals received
   6. Number of de-institutionalization candidates placed in the community
   7. Number of people referred and waiting for service
   8. Graph of unit PSR results

V. Referral Process
A. Ensure that referral packets are complete within established timeliness.
B. Calculate availability of time to accept new cases and call meeting of advisory committee when unit has the capacity to accept new cases.
C. Cancel meeting of advisory committee when unit does not have the capacity to accept new cases at least 1 week prior to a scheduled meeting.
D. Assign top priority cases to the available and appropriate behavior specialist for assessment and intervention plan services within 2 days of the committee meeting.

VI. Direct Service. Provide the services of a behavior specialist to a minimum of one case at all times. Score + if 85% level or better achieved on the behavior specialist performance review.
## INDIVIDUAL PERFORMANCE STANDARDS
### BEHAVIOR SERVICES SUPERVISOR SCORING SHEET

**Score Sheet**

**Name:** ____________________________________________________________________________________________________________

**Date of Evaluation:** _______________________________________________________________________________________________

**Evaluator:** _______________________________________________________________________________________________________

<table>
<thead>
<tr>
<th>Responsibilities</th>
<th>ACHIEVED</th>
<th>POSSIBLE</th>
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<tbody>
<tr>
<td><strong>I. Administration</strong></td>
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<tr>
<td>A. Attendance Sheets</td>
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<td>B. Personnel</td>
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<td>C. Time Sheets</td>
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<td>D. Staff Travel</td>
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<td><strong>II. Meetings</strong></td>
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<tr>
<td>A. Weekly Unit Meetings</td>
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<td>B. Monthly State Hospital Meetings</td>
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<td>C. Provider Meetings</td>
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<td>1. Weekly for State Hospital Case Load</td>
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<td>2. Monthly for Community Case Load</td>
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<td><strong>III. Supervision</strong></td>
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<tr>
<td>A. Provide 1:1 Supervision</td>
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<tr>
<td>1. 2 Hours Weekly for Intensive Intervention Team (IIT)</td>
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<td>2. 1.5 Hours Weekly for Behavior Specialist</td>
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<td>B. Evaluate Performance Reviews</td>
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<td>C. Field Visits</td>
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<td>D. Provider Evaluations — Social Validity</td>
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<tr>
<td>E. Reports</td>
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<tr>
<td>1. Assessment and Intervention Plan</td>
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<td>2. Quarterly Reports</td>
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<td>3. Termination Reports</td>
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<td>F. On-Call Supervision</td>
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<td><strong>IV. Direct Service</strong></td>
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**Total score possible** ____________________________

**Total score achieved** ____________________________

**Percentage score** ____________________________

**Comments/Issues/Recommendations:**
INDIVIDUAL PERFORMANCE STANDARDS

BEHAVIOR SERVICES SUPERVISORS

Operational Definitions

I. Administration

A. Receive attendance sheets from subordinate staff and verify appropriate use of service hours by comparing attendance sheet information with client authorization. Attendance sheets are initialed by the supervisor and are maintained in the behavior services unit files. Score + if all current attendance sheets are present in file.

B. Perform personnel-related responsibilities, including hiring and possible disciplinary actions for subordinate staff within policy and timelines. All personnel actions are maintained in behavior services unit personnel files. Score by a crosscheck of timelines and dates on personnel actions.

C. Ensure that staff timesheets are completed correctly, sign timesheets of subordinate staff, and deliver timesheets to the appropriate authority prior to noon on the final day of each pay period.

D. Approve use of private vehicles or state vehicles for official purposes. Approve travel claims, ensuring the accuracy of all travel claimed. Score + if no travel claims are returned for correction during the month.

II. Meetings

A. Attend weekly behavior services unit meetings. Submit names of individuals to be staffed to the unit manager no later than 2 days prior to the meeting. Score + if meeting minutes indicate presence (or excused absence) and if case name submitted as per above.

B. Attend monthly meetings with state hospital representatives. Present current status of each person on the state hospital list. Score + if meeting minutes indicate presence (or excused absence) and if current information is presented on each person.

C. Attend meetings with provider agencies providing service to behavior services unit clients to review progress and identify and resolve any problems

1. Weekly for intensive intervention and de-institutionalization case load
2. Monthly for other community case load

Score + if meeting minutes indicate presence and discussion as above.

III. Supervision

A. Provide 1:1 supervision of staff as follows

1. Two hours weekly for each intensive intervention specialist
2. One and a half hours weekly for each behavior specialist

Score + if results of each 1:1 meeting with staff are discussed with unit manager weekly.

B. Conduct formal checks on performance for all subordinate staff monthly. Score + if scores on all staff are submitted to unit manager 1 week before the end of each month.

C. Field Visits. Conduct at least one on-site observation of services being provided by each subordinate staff and document on the field observation checklist. Score + if results of each observation are discussed with unit manager monthly.

D. Social Validity Checks. Receive social validity checks from each provider (or KSA) monthly, discuss results with staff involved, and take corrective action as needed. Validity checks are maintained in behavior services unit files. Score + if results of each validity check are discussed with unit manager monthly.

E. Reports. Review, edit, return for revision, and approve the following reports from persons providing behavior specialist services

1. Assessment and Intervention Plan. One random report per month
2. Quarterly Reports. One random report per quarter
3. Termination Reports. One random report per quarter

F. On-Call Supervision. Be available by telephone or beeper for emergency supervision based on schedule. Score + if no reports received of unavailability during scheduled on-call hours.

IV. Direct Service. Provide the services of a behavior specialist to a minimum of one case at all times. Score + if 85% level or better achieved on the behavior specialist performance review.
INDIVIDUAL PERFORMANCE STANDARDS

BEHAVIOR SPECIALIST SCORING SHEET

Score Sheet

Name:  ____________________________________________________________________________________________

Date of Evaluation:  __________________________________________________________________________________

Evaluator: ___________________________________________________________________________________________

Responsibility

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<tbody>
<tr>
<td>A</td>
<td></td>
<td>Develop Behavior Assessments and Intervention Plans</td>
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<td>B</td>
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<td>Submit Plans on Timely Basis</td>
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<td>C</td>
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<td>Write Quarterly Progress Reports</td>
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<td>Submit Quarterly Reports on Timely Basis</td>
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<td>Write Termination Reports</td>
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<td>Provide Service as Authorized</td>
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<td>Submit Attendance Sheets</td>
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<td>Attend Weekly Unit Meetings</td>
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<td>Attend 1:1 Meetings with Supervisor</td>
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<td>Billable Service — Contract</td>
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<td>M</td>
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<td>Evaluate Assessment Reports for Other Specialists</td>
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<td>N</td>
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<td>O</td>
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<td>Monthly Progress Summary</td>
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<td>P</td>
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<td>Train Staff and KSAs</td>
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<td>Q</td>
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<td>Procedural Reliability</td>
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<td>Monthly Contact with Case Manager</td>
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<td>S</td>
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<td>Maintain Case Record</td>
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<td>T</td>
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<td>Competency-Based Training</td>
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<td>U</td>
<td></td>
<td>Periodic Service Review</td>
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<td>V</td>
<td></td>
<td>Notification of Abuse, and so on</td>
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<tr>
<td>W</td>
<td></td>
<td>85% on Monthly Field Observation Checklist</td>
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Total score possible _________________________________________
Total score achieved _________________________________________
Percentage score ___________________________________________

Comments/Issues/Recommendations

INDIVIDUAL PERFORMANCE STANDARDS

BEHAVIOR SPECIALIST

Operational Definitions

A. Develop comprehensive behavior assessments and intervention plans using the standard behavior services unit format as evidenced by an 85% score on the behavior services assessment checklist on one randomly selected service recipient per month.

B. Write and turn in for typing and/or editing behavior assessments and intervention plans within 30 days of assignment by supervisor, or within time-frames otherwise specified by supervisor in writing, as evidenced by an 85% score on the tracking cover sheet.

C. Write progress reports for each on a quarterly basis using the standard behavior services format as measured by an 85% score on the behavior services quarterly checklist on one randomly selected individual client.

D. Write and turn in for typing and/or editing a quarterly progress report for each person within 2 weeks prior to the end of the quarter and authorization, as evidenced by an 85% score on the tracking cover sheet.

E. Write a termination report as needed using the behavior services standard format as evidenced by an 85% score on the behavior services termination checklist on one randomly selected person.

F. Write and turn in for typing and/or editing a termination report within 30 days after intervention services have ceased, as evidenced by an 85% score on the tracking cover sheet.

G. Provide only those services within the parameters of the formal authorization regarding both the number of hours and the length of service, as evidenced by a 100% crosscheck of attendance sheets and authorization.

H. Submit completed and accurate attendance sheets no later than the first day of the month following the service month.

I. Attend weekly behavior services unit meetings. Score + if meeting minutes indicate the presence (or excused absence).

J. Attend individual sessions on the required basis of 1 hour of face-to-face supervision per 20 hours of direct service per month, as measured by supervisor documentation.

K. Behavior specialists hired on a contract basis will be responsible for providing a minimum of three cases of billable services per month, as indicated by monthly billing sheet. (Note — Non-applicable at this time).

L. Behavior specialist hired on a full-time basis will be responsible for providing at least 120 hours of direct service per month, as indicated on attendance sheet.

M. Evaluate one report of another specialist per month using standard evaluation form, as indicated by copy of completed review checklist turned into supervisor.

N. Summarize individual data on a monthly basis, as evidenced by direct observation of case file per month updated within 1 week.

O. Complete a monthly progress summary for each individual on your case load and submit each to the case manager within 5 working days of the end of the month. A copy will be retained in the behavior services unit master record. This will be measured by direct observation of master record on one randomly selected person per month.

P. Train designated key social agents to implement intervention procedures to a procedural reliability and interobserver reliability score of 90% within 30 days of implementation, as indicated on the behavior performance competency checklist (BPCC) of one randomly selected person.

Q. Conduct procedural reliability checks as prescribed on key social agents trained. Ensure maintenance of a score of 85%, as indicated on the procedural reliability checklist based on one randomly selected person per month.

R. Document at least one telephone contact per month to the case manager, as evidenced by written documentation on the client contact log based on one randomly selected person per month.

S. Maintain all required documentation for client file as evidenced by one randomly selected case file per month.

T. Complete competency-based training as required. (Note — Non-applicable at this time).

U. A Periodic Service Review is developed for each service site. Service providers are trained to assume responsibility for all items on the PSR, to achieve an initial 90% level within 30 days of implementation, and to maintain an 85% level or better, based on monthly formal PSR checks.

V. Notify appropriate agencies, in accordance with legal requirements, of suspected abuse, neglect and/or violation of client rights, and document such incidents in client contact log and/or case notes, and in 1:1 supervisory meetings. This item to be measured by observation of written documentation in one randomly selected case record. Score + if an incident is documented and a report made or there is documentation of why incident was not reported. Score O if no documentation exists for a known incident, and N/A if there are no incidents known or documented.

W. Maintain at least an 85% score on the monthly field observation checklist as completed by the supervisor during the field visit.
### INDIVIDUAL PERFORMANCE STANDARDS

**INTENSIVE INTERVENTION SPECIALIST SCORING SHEET**

**Score Sheet**

Name: ____________________________

Date of Evaluation: ___________________________________________________________________________

Evaluator: _____________________________________________________________________________________

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>ACHIEVED</th>
<th>POSSIBLE</th>
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<tbody>
<tr>
<td>A. Arrives on Time</td>
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<tr>
<td>B. Notifies Supervisor of Absences</td>
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<td></td>
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<tr>
<td>C. Maintains Daily Data</td>
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<td>D. Data Summary Sheet</td>
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<td>E. Daily Graphs</td>
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<td>F. Procedural Reliability</td>
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<td>G. Interobserver Reliability</td>
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<tr>
<td>H. Activity Schedule</td>
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<tr>
<td>I. Competency-Based Training</td>
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<tr>
<td>J. Weekly Team Meetings</td>
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<tr>
<td>F. Rules/Standards of Host</td>
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<tr>
<td>L. Notifies Supervisor of Conflicts</td>
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<td>M. Incident Reports</td>
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<td>N. Ethical Standards</td>
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<td>O. Social Validity</td>
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<td>P. Appearance</td>
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<tr>
<td>Q. Notification of Abuse, and so on</td>
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<tr>
<td>R. Periodic Service Review</td>
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<tr>
<td>S. Trains Staff and KSAs</td>
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<td>T. Attendance Sheets</td>
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<tr>
<td>U. Time sheets</td>
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</tbody>
</table>

Total possible points ____________________________

Total points achieved ____________________________

Percentage score ____________________________

**Comments/Issues/Recommendations:**

__________________________
INDIVIDUAL PERFORMANCE STANDARDS

INTENSIVE INTERVENTION SPECIALIST

Operational Definitions

A. Arrive within 5 minutes of scheduled time at least 80% of working days in a month. Arrive between 5 and 15 minutes no more than the remaining 20% of the time. Remain until end of assigned shift. Items are scored by direct observation and review of sign-in sheet maintained at the intensive intervention site.

B. Notify supervisor of absences
   1. No later than 1 hour before start of shift, when absent due to illness. In addition, notify appropriate person at intensive site within the same time period. Score based on crosscheck with sign-in sheet and supervisor’s documentation of calls.
   2. At least 2 weeks in advance of requested use of annual leave in excess of 2 days.
   3. At least 24 hours in advance of other known absences.

C. Maintain all data daily, as prescribed by behavior specialist per task based on one randomly selected individual per week.

D. Maintain data summary sheet, as prescribed by behavior specialist based on one randomly selected person per week.

E. Graph all data daily at end of shift, as prescribed by behavior specialist based on one randomly selected person per week.

F. Adhere to programs as designed by behavior specialist and meets procedural reliability criteria of 90%, as measured weekly for one randomly selected service recipient per provider.

G. Meet 85% of criteria of interobserver reliability monthly, or as otherwise prescribed for all individuals documented in each case file.

H. Carry out schedule of activities at 85% level or better based on one randomly selected person per month. Schedule is posted in the program setting, and activities are documented in an activity log maintained in the program setting.

I. Complete competency-based training as specified (Note — non-applicable at this time).

J. Attend weekly provider meetings with supervisor, host facility supervisor, and staff (or KSAs), and, if applicable, fellow intensive staff, as documented in meeting minutes.

K. Adhere to rules and standards of dress and behavior of host facility/environment, unless directed otherwise, as measured on monthly social validity checks completed by the host agency/family.

L. Notify supervisor of conflicts or concerns with host staff/family within 24 hours of end of shift. This item is scored + if no issues are raised at the weekly provider meeting that the supervisor has not been notified of by the intensive intervention staff, except for those issues of which staff were not aware.

M. Complete unusual incident reports when necessary as prescribed, and notifies the supervisor orally by the end of shift. All other incidents are reported to the supervisor within 24 hours. Written incident reports must be submitted to the host facility supervisor by the end of the next working day for review and filing in the master record. This item is rated + if an incident is documented and a report is made, O if there is no documentation of a known incident, and N/A if no incidents are reported or documented.

N. Maintain ethical standards of confidentiality and client dignity. Do not disclose identifying information, confidential reports of client likeness without express written permission of supervisor and responsible person, in accordance with applicable laws. This item is rated + if required approvals are obtained prior to disclosure, O if disclosure is reported without required approvals, and N/A if no disclosures are made.

O. Maintain a 3 or higher on each criterion measured on the monthly social validity checks, as submitted by the host facility/family to the behavior services unit supervisor.

P. Upon arrival at host/facility home, ensure that individual receiving services is dressed and neatly groomed in an age-appropriate manner and notes discrepancies in the case notes section of the case file. Appearance is evaluated by weekly observation by supervisor.

Q. Notify appropriate agencies, in accordance with legal requirements, of suspected abuse, neglect, and/or violation of client rights. Notify supervisor of all such notification by end of shift and document such incidents in case notes. This item is measured by observation of written documentation in one randomly selected clients case record. Score + if incident is documented and report made, or there is documentation of why incident was not reported, O if there is no documentation of a known incident, and N/A if no incidents are known or documented.

R. A Periodic Service Review is developed for each service site. Service providers are trained to assume responsibility for all items on the PSR, to achieve an initial 90% level within 30 days of implementation, and to maintain an 85% level or better based on monthly formal PSR checks.

S. Train designated key social agents to implement programs at 90% criteria of procedural reliability and interobserver reliability, as specified in the intensive intervention fading plan that is maintained at the program site. Documentation of training is maintained on behavior performance competency checklist.

T. Submit completed and accurate attendance sheets no later than the first working day of the month following the month of service. All attendance sheets must reflect only authorized hours.

U. Submit complete and accurate time sheets no earlier than the Wednesday and no later than the Thursday prior to the end of each pay period.
The Periodic Service Review (PSR) is a service evaluation instrument designed to assess the consistency of support staff involved with a service recipient, the ability of the staff to implement recommendations regarding services, and the overall quality of the services being provided.

It is important to remember that the PSR looks at the overall services for a person and that one particular staff may not be responsible for every item evaluated. When opportunities to improve are found, it will be noted who is responsible for this improvement. The staff responsible needs to take advantage of the opportunity in a timely manner or ask their supervisor for help. Any variation and/or exception to PSR items should be documented on the PSR variation form and must be signed and approved by each area manager.
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<tr>
<th>Target Date</th>
<th>Score</th>
<th>Person Responsible</th>
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<tbody>
<tr>
<td><strong>A. General Service Activities</strong></td>
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<tr>
<td>1. Individual Schedule</td>
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<td>2. Staff Schedule</td>
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<tr>
<td>3. Substitute Instructions</td>
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<tr>
<td>4. Standard Graphs and/or tables complete</td>
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<tr>
<td>5. Spot Checks: AA &amp; Functional</td>
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<td>6. No Aversives Used</td>
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<td>7. Special Incidents</td>
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<td>8. First Week Protocol</td>
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<td>9. Time Spent in Community</td>
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<td>10. Social Skills Training/PET</td>
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<td><strong>B. Service Delivery/Individual Service Plan</strong></td>
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<td>c Graph/Other Data Summary</td>
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<td>Graph/Other Data Summary</td>
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2. Reliability On: ______________________________
   a. Interobserver
   b. Procedural

3. ISP Complete

4. Objectives Met

5. Community Integration Plan

6. Social Integration

C. Health and Safety
   1. Medication Given Appropriately
   2. Medication Stored Appropriately
   3. Medication Chart
   4. Medication Count Sheet
   5. Disposal of Medication
   6. Medication Treatment Plan
   7. Medication Protocols
   8. Fire Drills
   9. Escape Routes
   10. Fire Extinguisher
   11. Earthquake Tornado Drills
   12. Earthquake/Hurricane Preparedness
   13. Emergency Contact Drill
   14. Menu Documented
   15. Menu Followed
   16. Medical/Dental Evals
   17. Medical Contact

D. Finances and Budgeting
   1. Financial Responsibility Policy
   2. Reconciliation of Personal Monies
   3. Bills Paid
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<th>E. Positive Futures Plan</th>
<th>Score</th>
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<td>1. Personal Profile Session</td>
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<td>2. Futures Planning Session</td>
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<td>3. Circle of Support Logistics</td>
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<td>4. Circle of Support Content</td>
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<td>5. Circle of Support Composition</td>
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<td>F. Staff Development</td>
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<td>1. CBT’s Complete</td>
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<td>2. Staff Meetings/Inservices</td>
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<td>4. House Meetings</td>
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<td>5. Consumer Evals</td>
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<td>7. Professionalism</td>
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<td>8. Attendance/Punctuality</td>
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<td>9. Individual Case file</td>
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<td>10. Case Notes/Log</td>
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<td>11. Staff log/shift change checklist or communication book</td>
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<td>12. Support Plan Notebook</td>
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<td>13. Personal Phone Calls</td>
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<tr>
<td>14. Field Visit by Management Staff</td>
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Total Score Achieved

Total Score Possible

Percentage Score

COMMENTS

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
A. General Service Activities.
   1. Individual Schedule.
      a. **What.** A day planner, personal appointment book or calendar is maintained.
      b. **When.** Daily or weekly.
      c. **Who.** Each individual receiving services.
      d. **How.** Based on a review of the planner, book or calendar, a “+” is scored if:
         1) If it is current rather than rote;
         2) There is evidence of at least one personally chosen recreational/leisure activity in the previous week; and
         3) There is evidence of at least one instructional lesson that week for learning a personally selected skill.
   Modifications to these criteria can be accepted with a signed and dated approval by the service manager documented in the support plan notebook on the PSR Variations Form.

   2. Staff Schedule.
      a. **What.** Staff schedules are maintained in central office and the apartments.
      b. **When.** Changed as needed to remain current.
      c. **Who.** Contract person.
      d. **How.** Based on a review of the current schedules and the contact person’s documentation, a “+” is scored if the schedules indicate the person currently working or variations have been recorded by the contact person or other designated person.

   3. Substitute Instructions.
      a. **What.** Substitute instruction are maintained.
      b. **When.** Kept current.
      c. **Who.** Contact person.
      d. **How.** Based on a review of the Substitute Instruction Form, a “+” is scored if it is dated and signed by the responsible contact person, confirmed as current at least monthly, it is completely filled out, and relevant protocols are attached. If medications are indicated, the instructions must be consistent with the medication chart.

   4. Standard Graphs and/or Tables Complete.
      a. **What.** Standards graphs or tables are maintained for tracking apartment tenure and the quality and number of occasions spent in community integrated activities (i.e., one time, short term and long term).
      b. **When.** Updated within three working days of close of month.
      c. **Who.** Contact person.
      d. **How.** Based on a review of the standard graphs and/or tables, a “+” is scored if they are current, dated (including the year), and clearly labeled and if the definitions of the different categories of community activities are available in the notebook. This item can be prorated out of two.

      a. **What.** Consumers engage in age-appropriate and functional activities.
      b. **When.** At all times.
      c. **Who.** Entire support team, including the consumer.
      d. **How.** Based on the documentation for the last scheduled spot check (see Item F-14), a “+” is scored if the criteria were met for age-appropriate and functional activities.

   6. No Aversives Used.
      a. **What.** Staff are positive with consumers.
      b. **When.** At all times.
      c. **Who.** All staff.
      d. **How.** Based on the documentation from the last scheduled spot check (see Item F-14), a “+” is scored if the criteria were met for positive interactions with consumers and there have been no reports of aversive treatment from consumers, their families, other staff, or any other person since the last PSR review.

   7. Special Incidents.
      a. **What.** Special incidents are reported as required by policy.
      b. **When.** Within 24-hours of the incident.
      c. **Who.** Staff who witness incident.
      d. **How.** Based on a review of the special incident report section in the consumer file (case file) and the special incident section of the consumer notebook, a “+” is scored if all special incidents that have been filed since previous PSR check, if any, are detailed, follow Special Incident Reporting procedures and the Manager is not aware of any events that should have been reported but weren’t in a timely and accurate basis.

      a. **What.** The First Week Protocol is completed.
      b. **When.** By end of each consumer’s first week of service or end of first week each time the person moves into a new home.
      c. **Who.** Manager.
      d. **How.** Based on a review of the First Week Protocol checklist, a “+” is scored if it is available in the designated section of the consumer case file and in the first month of service or within the first month of a consumer’s move into a new home, indicates that all necessary items were completed on time or if after the first month of service or move is available and complete.

      a. **What.** Staff spends the allotted amount of time with the individual in the community.
      b. **When.** Within 30-60 days of service initiation and as specified in the ISP.
      c. **Who.** Support staff.
      d. **How.** Based on a review of the consumer’s ISP and the current Community Activities Log (CAL), a “+” is scored if the community activities
10. Social Skills Training
   a. **What.** Consumers attend at least one social skills instructional session.
   b. **When.** Per week or as otherwise specified in the ISP.
   c. **Who.** Support staff.
   d. **How.** Based on a review of the ISP and current Social Skills Training records, a “+” is scored if the consumer attended the specified session(s) for the past week. This may not apply if documented on the PSR Variations Form.

B. Service Delivery/Individual Service Plan

1. Support Plans Implemented. There should be one or more support plans/teaching methods for each ISP objective (which should be distinguished from ISP activities). To score PSR, list key word or phrase (e.g., cooking, cleaning, grooming, shopping, budgeting, etc.). Any exceptions must be documented on the PSR Variations Form.
   a. **Protocol:**
      1) **What.** For each identified method in the support plan, there is a written protocol, i.e., a written step by step description of how that particular service is to be provided.
      2) **When.** Within 30 days of ISP meeting date or within one week of revision of or addition to the ISP.
      3) **Who.** Contact person.
      4) **How.** Based on a review of the ISP and the protocols in the support plan notebook, a “+” is scored if:
         a) There is at least one protocol associated with the ISP objective;
         b) It lists or otherwise describes in step by step detail how to implement the procedure or method;
         c) It clearly describes the frequency and method for determining and documenting procedural reliability.
         d) It clearly describes the method for data collection and data summary that should be used to evaluate the success of the procedure, including the frequency and methods for determining and documenting observational reliability;
         e) It clearly indicates the Pass/Fail criteria; i.e., the criteria indicating success requiring that plan move on to the next step and the criteria indicating failure requiring a revision of the method to assure success.
   b. **Data Sheet:**
      1) **What.** For each ISP objective, there is a corresponding data sheet.
      2) **When.** By the end of the day or as specified in the protocol.
      3) **Who.** Support staff.
      4) **How.** Based on a review of each protocol and the associated data sheet, a “+” is scored if:
         a) The data sheet is up to date as specified in the protocol;
         b) The last scheduled reliability check was carried out and documented; and
         c) The reliability index was calculated at the 85% level or met other criteria that may have been prescribed on the protocol.

c. **Graph or Other Data Summary:**
   1) **What.** For each ISP objective, there is a corresponding data summary.
   2) **When.** By the end of the week or as specified in the protocol.
   3) **Who.** Support staff.
   4) **How.** Based on a review of each protocol and the associated data sheet and data summary, a “+” is scored if:
      a) The prescribed summary is up to date as specified in the protocol;
      b) The summary corresponds to the data sheet for all data points since the last check; and
      c) The summary is clearly and fully labeled, including an indication of the year.

2. Reliability Checks - At least quarterly, or more frequently if indicated in the protocol, staff carry out inter-observer and procedural reliability checks. Exceptions should be noted on the PSR Variations Form.
   a. **Inter-observer:**
      1) **What.** For each set of data, there is corresponding documentation of ongoing inter-observer reliability checks.
      2) **When.** At least quarterly or as specified on protocol.
      3) **Who.** Management staff.
      4) **How.** Based on a review of each set of data, a “+” is scored if:
         a) The last scheduled reliability check was carried out and documented; and
         b) The reliability index was calculated at the 85% level or better or met other criteria that may have been prescribed on the protocol.
   b. **Procedural:**
      1) **What.** For each protocol, there is corresponding documentation of ongoing procedural reliability checks.
      2) **When.** At least quarterly or as specified on protocol.
      3) **Who.** Management staff.
      4) **How.** Based on a review of the procedural reliability documentation, a “+” is scored if:
         a) The last scheduled reliability check was carried out and documented; and
         b) The reliability index was calculated at the 85% level or better or met other criteria that may have been prescribed on the protocol.

3. ISP Complete:
   a. **What.** SCIP ISP and quarterly updates are complete and timely.
   b. **When.** Within 60 days of entering service, during the consumer’s birth month, by the 10th of the month after the quarter ends, or as otherwise specified on the PSR Variations Form.
   c. **Who.** Management staff.
   d. **How.** Based on a review of the ISP and quarterly updates in the support plan notebook, a “+” is scored if:
      1) The ISP and all quarterly updates are on file;
      2) Are up to date; and
      3) Include all of the information required on the quality checklist.

4. Objectives Met:
   a. **What.** ISP objectives are being met.
   b. **When.** As established on the ISP and quarterly updates.
c. **Who.** Management staff.
d. **How.** Based on a review of the last current quarterly update; credit is given for each objective that has been met out of the total number possible [e.g., 3/4].

5. **Community Integration Plan:**
   a. **What.** Every consumer has an active Community Integration Plan (CIP).
   b. **When.** Within 60 days of enrollment.
   c. **Who.** Management staff.
d. **How.** Based on a review of the CIP, a “+” is scored if:
   1) It is current and filed in the support plan notebook; and
   2) Includes all of the items required on the CIP quality checklist, including but not limited to participation in community and socially integrated activities as determined by the person’s interests, abilities and personal goals and objectives.

6. **Social Integration:**
   a. **What.** Each consumer attends socially integrated activities.
   b. **When.** Regularly.
   c. **Who.** Support staff.
d. **How.** Based on a review of the person’s Community Integration Plan (CIP), CAL, day planner, individual report and the documentation from the last scheduled spot check, a “+” is scored if last month the person attended 80% of the activities established on the CIP.

C. **Health and Safety.**
   1. **Medication Given Appropriately:**
      a. **What.** Medication is given as prescribed.
      b. **When.** As prescribed.
      c. **Who.** Support staff.
d. **How.** Based on a review of medication labels, physician’s orders and the medication chart, a “+” is scored if:
      1) Each medication has a written order signed by a physician [verbal or phone orders must be documented appropriately and signed by a physician within 72 hours]; and
      2) Physician’s order(s) is [are] consistent with the medication chart(s) and medication label(s).

   2. **Medication Stored Appropriately:**
      a. **What.** Medication is safely stored.
      b. **When.** When not being given.
      c. **Who.** Support staff.
d. **How.** Based on observation of medication storage box and a review of the PSR Variations Form, a “+” is scored if:
      1) It is being stored in a safe, discrete place; and
      2) It is locked, if the need for this is indicated on the PSR Variations Form.

3. **Medication Chart:**
   a. **What.** Medication chart is accurate and current.
   b. **When.** Filled out as medication is given.
   c. **Who.** Support staff.
d. **How.** Based on a review of the medication chart and the person’s medication bottles, a “+” is scored if:
   1) It is filled out correctly; and
   2) Includes information from last time medication was taken by the individual.

4. **Medication Count Sheet:**
   a. **What.** Medication Count Sheet is filled out correctly.
   b. **When.** Weekly.
   c. **Who.** Support staff.
d. **How.** Based on a review of the Medication Count Sheet and the documentation of the last scheduled Spot Check a “+” is scored if:
   1) The Medication Count Sheet is filled out correctly;
   2) It is up-to-date; and
   3) The last spot check indicated that it was accurate.

5. **Disposal of Medication:**
   a. **What.** Medication is properly disposed of.
   b. **When.** As necessary.
   c. **Who.** Support staff.
d. **How.** Based on a review of the medication chart, the medication count sheet and the relevant incident report(s), a “+” is scored if:
   1) Any medication that was disposed of since the last PSR was done so in the correct way; and
   2) Was properly documented.

6. **Medication Treatment Plan:**
   a. **What.** Medication treatment plans are available.
   b. **When.** Prior to medication being given.
   c. **Who.** Management staff.
d. **How.** Based on a review of the medication treatment plans and the medication bottles, a “+” is scored if:
   1) The medication treatment plans are correct; and
   2) One is available for each.

7. **Medication Protocol:**
   a. **What.** Protocols are available for self-medication.
   b. **When.** Prior to self-medication.
   c. **Who.** Support staff.
d. **How.** Based on a review of physician’s orders and medication protocols, a “+” is scored if:
   1) The protocol has been properly prepared and approved; and
   2) Staff documentation on the protocol indicates that it is being followed.

8. **Fire Drills:**
   a. **What.** Fire drills are carried out.
   b. **When.** Monthly.
   c. **Who.** Support staff.
d. **How.** Based on a review of the Emergency Checklist, a “+” is scored if:
   1) A fire evacuation drill was held during the prior month; and
   2) It was completely documented on the Emergency Checklist.

9. **Escape Routes:**
   a. **What.** Two escape routes from the house have been identified.
   b. **When.** Kept on display.
   c. **Who.** Support staff.
d. **How.** Based on observation, a “+” is scored if there is posted in the home.

10. **Fire Extinguisher:**
    a. **What.** Fire extinguisher is available.
    b. **When.** Always.
    c. **Who.** Support staff.
d. **How.** Based on a review of the fire extinguisher and the Emergency Checklist, a “+” is scored if:
    1) The fire extinguisher is kept in an accessible area;
11. Earthquake/Tornado Drills
a. What. Earthquake/Tornado drills are carried out.
c. Who. Support staff.
d. How. Based on a review of the Emergency Checklist, a “+” is scored if:
   1) An earthquake/tornado drill was held during the prior month; and
   2) It was completely documented on the Emergency Checklist.

12. Earthquake/Hurricane Preparedness:
   a. What. Earthquake/Hurricane Preparedness Kits are available.
   b. When. Within 30-days of moving in.
   c. Who. Support staff.
   d. How. Based on a review of the Emergency Checklist, a “+” is scored if:
      1) An Earthquake/Hurricane Preparedness Kit is readily available; and
      2) Has all of the required items.

13. Emergency Contact Drill:
   a. What. Emergency drills are carried out.
   c. Who. Support staff.
   d. How. Based on a review of the Emergency Checklist, a “+” is scored if:
      1) A beeper and 911 drills were held during the prior month for all shifts; and
      2) They were completely documented on the Emergency Checklist.

14. Menu Documented:
   a. What. Written menus.
   b. When. Daily.
   c. Who. Support staff.
   d. How. Based on a review of the last scheduled spot check, a “+” is scored if:
      1) Written menus were available for the past week and followed the dietary guidelines. This may be waived if a consumer has these skills and this is documented on the PSR Variations Form.

15. Menu Followed:
   a. What. Menus are followed.
   b. When. Daily.
   c. Who. Support staff.
   d. How. Based on a review of the documentation for the last spot check, a “+” is scored if:
      1) Menu variations and changes were indicated; and
      2) It was followed 90% of the time.

16. Medical and Dental Evaluations:
   a. What. Medical and dental evaluations are carried out.
   b. When. Within 30-days of receiving services and annually thereafter. If an individual has had a medical or dental exam within the three months prior to receiving SCIP services, annual appointments only need to be done.
   c. Who. Support staff.
   d. How. Based on a review of the Physician’s and Dentist’s Recommendations Form, a “+” is scored if the most recent evaluations were carried out in a timely manner.

17. Medical Contacts:
   a. What. Medical resources are identified.
   b. When. By the first day of service.
   c. Who. Support staff.
   d. How. Based on a review of the face sheet in the support plan notebook, a “+” is scored if it indicates the names, phone numbers and addresses of the doctor, dentist and hospital that can be used if needed.

D. Finances and Budgeting
1. Financial Responsibility Policy:
   a. What. Financial responsibility policy is explained.
   b. When. Upon intake.
   c. Who. Management staff.
   d. How. Based on a review of the case file, a “+” is scored if all consumer’s, parents or other responsible parties have signed a copy of the financial responsibility policy indicating that they have read and understood it.

2. Reconciliation of Consumer Moneys:
   a. What. Consumer moneys are accounted for.
   b. When. Weekly.
   c. Who. Support staff.
   d. How. Based on a review of the weekly reconciliation sheets for the period since the previous PSR, a “+” is scored if:
      1) The appropriate form was used;
      2) The form was completed; and
      3) Moneys were accounted for to the nearest $1.00

3. Bills Paid. Bills are paid by due date on bill, and no late charges nor service interruption have been incurred within month. If this is a specific issue for a person, a written plan is in place and implemented.
   a. What. Consumer household bills are paid on time.
   c. Who. Support staff.
   d. How. Based on a review of the consumer’s budget, check book and bill’s for the previous month, a “+” is scored if:
      1) All bills were paid by due date;
      2) No late charges were incurred;
      3) There have been no service interruptions; and
      4) If paying bills on time has been an issue, a plan has been written and implemented.

E. Positive Futures Plan
1. Personal Profile Session:
   a. What. A consumer profile is developed.
   b. When. Before services are initiated.
   c. Who. Management staff.
   d. How. Based on a review of the Personal Profile and Positive Futures Plan, a “+” is scored if the profile has been competed.

2. Futures Plan Sessions:
   a. What. Each consumer has a Positive Futures Plan.
   b. When. Within 30-days of service initiation.
   c. Who. Management staff.
   d. How. Based on a review of the Positive Futures Plan, a “+” is scored if it was completed within the first 30-days of service.

3. Circle of Support Logistics:
   b. When. Once per quarter unless special circumstances arise.
   c. Who. Focus person and/or appointed secretary are responsible for meeting invitations and meeting coordination and for preparing and distributing minutes.
   d. How. Based on a review of meeting minutes, a “+” is scored if:
1) Minutes for the last meeting are available;
2) Were distributed within one week of the meeting; and
3) Indicate that the meeting was held within the quarter or as otherwise scheduled at the immediately preceding meeting.

4. **Circle of Support Content**
   a. **What.** Circle agenda is followed and tasks are completed.
   b. **When.** At or by circle meetings or as otherwise scheduled.
   c. **Who.** Circle members.
   d. **How.** Based on a review of the last meeting minutes, a “+” is scored if:
      1) The standard agenda was followed;
      2) A new task grid was established; and
      3) At least 75% of the previous task grid was completed.

5. **Circle of Support Composition**
   a. **What.** The composition of a circle of support includes friends, family, and other people who are not paid staff and who attend circle meetings regularly.
   b. **When.** Quarterly or as otherwise scheduled.
   c. **Who.** All people in the circle, including the focus person, are responsible for identifying and recruiting potential members. The appointed secretary of the circle, however, is responsible for sending out written meeting invitations at least one week prior to a meeting. Management has the responsibility for developing and revising our system to improve our ability to meet this standard.
   d. **How.** Based on a review of the last two meeting minutes, a “+” is scored if at least one who attended was neither IABA® staff nor roommates.

F. **Staff Development**

1. **CBT’s Complete**
   a. **What.** All staff complete competency based training.
   b. **When.** Seven of the 16 topics should be completed during the first week of employment, one additional topic during each subsequent two weeks of employment, 13 within three months of employment and all 16 within the first six months of employment, or as otherwise scheduled in writing by the Manager.
   c. **Who.** All staff.
   d. **How.** Based on a review of the CBT control sheet, a “+” is scored if all staff are on target with the above schedule.

2. **Staff Meetings/Inservices**
   a. **What.** Staff attend mandatory staff meetings and inservice sessions.
   b. **When.** Monthly staff meetings and quarterly inservice sessions.
   c. **Who.** All designated staff.
   d. **How.** Based on a review of the last month’s staff meeting and last quarter’s inservice minutes, a “+” is scored if all staff attended or were excused in writing from attending by the Manager.

3. **Contact Meetings**
   a. **What.** Staff attend contact meetings.
   b. **When.** Weekly or as otherwise scheduled.
   c. **Who.** Support staff.
   d. **How.** Based on a review of the minutes and/or the contact meeting agenda form for the last scheduled contact meeting, a “+” is scored if:
      1) All appropriate staff attended; and
      2) All tasks assigned at previous contact meeting were completed on schedule.

4. **House Meetings**
   a. **What.** House meetings are held.
   b. **When.** Monthly or as otherwise scheduled.
   c. **Who.** Residents, contact person, and designated staff & the Manager and/or Supervisor, every other quarter.
   d. **How.** Based on a review of house meeting minutes and the weekly management meeting minutes, a “+” is scored if:
      1) A house meeting was held in the previous month or as otherwise scheduled;
      2) Minutes were taken by the contact person or a designated alternate;
      3) House meetings were discussed at the weekly management meeting; and
      4) The manager and/or supervisor attended within the last six months.

5. **Consumer Evaluations**
   a. **What.** Staff are evaluated by consumers.
   b. **When.** Monthly.
   c. **Who.** Management.
   d. **How.** Based on a review of consumer evaluation forms, a “+” is scored if:
      1) At least one consumer evaluation cycle was completed in the previous month; and
      2) Staff are rated at least satisfactory or the involved staff person is working on resolving any difficulties in the relationship as documented in the contact meeting minutes.

6. **Landlord Concerns Log**
   a. **What.** A landlord feedback form documents landlord concerns.
   b. **When.** Every time there is a concern from the landlord.
   c. **Who.** Management staff.
   d. **How.** Based on a review of the landlord concern logs and the contact meeting minutes for the previous month, a “+” is scored if all known concerns were logged and appropriate follow-up action was taken.

7. **Professionalism**
   a. **What.** Staff appropriately attired for work, exhibits positive attitude and acts in accordance with individual’s rights and advocacy.
   b. **When.** At all times.
   c. **Who.** Support staff.
   d. **How.** Based on the documentation for the last scheduled management spot check and the case notes, a “+” is scored if there have been no problems or conflicts in this category between or during spot checks.

8. **Attendance/Punctuality**
   a. **What.** Staff follow protocol for absences or lateness.
   b. **When.** Whenever staff is late or absent
   c. **Who.** Support staff.
   d. **How.** Based on a review of staff attendance record and management documentation, a “+” is scored if:
      1) Staff arrived on time and attended each assigned work shift since the last check (except for pre-specified time off or emergency) or;
      2) Staff followed protocol for any absence or late arrival to work.
9. **Individual Case File.**
   a. **What.** Individual Case File maintained in central office.
   b. **When.** Updated by 5th of the month.
   c. **Who.** All staff.
   d. **How.** Based on a review of the Individual Case File, a “+” is scored if:
      1) The results of an annual audit show that an audit has been carried out within the previous 12 months;
      2) The Case File contained all items listed on the Case File Checklist (after the first month following the annual audit, credit can be given if missing items have been subsequently filed);
      3) The Case File is organized based on the Case File Checklist; and
      4) The Case File is updated by the 5th of the month.

10. **Case Notes.**
    a. **What.** Anecdotal case notes about individual progress, problems, concerns.
    b. **When.** Once a week and then filed in Case File within 5 days of close of the month.
    c. **Who.** Support staff (all shifts)
    d. **How.** Based on a review of the case notes section located in the Support Plan Notebook and the Case File, a “+” is scored if:
        1) There is a weekly case note entry dated and signed by the responsible staff for each shift; and
        2) All previous case notes have been filed in the Case File within 5 days of the close of the month.

11. **Staff Log/Shift Change Checklist or Communication Book.**
    a. **What.** Staff Log and/or Shift Change Checklist or Staff Communication Book are maintained for each shift.
    b. **When.** Daily.
    c. **Who.** Support staff (all shifts)
    d. **How.** Based on a review of Staff Log and Shift Change Checklists, and documentation of the last scheduled Spot Check”, a “+” is scored if:
        1) There is a completed, daily logs and checklists for each shift.

12. **Support Plan Notebook.**
    b. **When.** Changed as needed to remain current.
    c. **Who.** Support staff.
    d. **How.** Based on a review of the Support Plan Notebook, a “+” is scored if:
        1) Notebook is accessible;
        2) Follows Model Notebook Outline and;
        3) All information is current

13. **Personal Phone Calls.**
    a. **What.** Staff personal phone calls using phone of service recipient.
    b. **When.** Only if absolutely necessary and with prior approval by supervisor (emergency call cleared within 24 hours).
    c. **Who.** All staff.
    d. **How.** Based on a review of the telephone log and/or phone bill, a “+” is scored if:
        1) There is a telephone log being maintained;
        2) There are no unexplained calls on the monthly telephone bill, and;
        3) There are no other indications of staff personal phone calls made without approval.

14. **Field Visit by Management Staff.**
    a. **What.** A visit is made to each person’s home.
    b. **When.** At least once per month.
    c. **Who.** The Service Manager, Supervisor or Unassigned Senior
    d. **How.** Based on a review of the case file, a “+” is scored if there have been at least one home visits made by the service manager, supervisor or unassigned senior during the previous month and each visit has been documented in the case file. An ISP meeting cannot be counted for the visit unless management staff stayed one-half hour or longer before or after the meeting.
# STEP PSR SCORING SHEET

## Services to Employ People

### Periodic Service Review

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<th>Comments</th>
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<td>2. Sub Instructions</td>
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<th>B. Individual Service Plan</th>
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<td>Plans Implemented</td>
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<td>2. List Plans</td>
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<td>b. Data sheet</td>
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<td>d. Interobserver Reliability</td>
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<td>3. Monthly Data Summary</td>
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<td>4. ISP Complete</td>
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<tr>
<td>5. Objectives Met*</td>
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**COMMENTS:**

- Specialist: _____________________________________________
- Rater: ________________________________________________
- Location of Rating: _____________________________________
- Client Name: __________________________________________
- Date: _________________________________________________
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<tr>
<th>Administrative</th>
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<tr>
<td>1. Client Case File</td>
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<td>2. Job Notebook</td>
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<td>6. TJTC/SSI</td>
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<td>7. Subminimum/Productivity</td>
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Score + or “O” on each item of PSR according to the criteria outlined below.

**GENERAL ACTIVITIES:**
1. **Daily Schedule of Activities** - Accessible (copy in job notebook) and followed; list of activities by times of day for 6-hour program day, including training toward all ISP objectives.
2. **Substitute Instructions** - Detailed and updated instructions for substitutes in Office File and on site.
3. **Job Description** - List of tasks and job duties in job notebook.
4. **Curriculum Functional and Age Appropriate During Spot Checks.** - Spot checks done monthly and client is engaging in meaningful activities engaged in by others of same age.
5. **Standard Graphs Complete** - Client has monthly job tenure and earnings graph, which are clearly labeled and detailed with work demographics. Updated within three working days of close of month. This item can be prorated out of 2.
6. **Emergency Procedures**
   a. **Behavior Problems** - When emergency behavior intervention is necessary, a written plan is in job notebook and client file and is followed correctly.
   b. **Special Incidents** - When these occur, they are handled appropriately, including documentation to supervisors and other agencies.
   c. **Medical Problems** - Where medical problems exist, such as seizures, there is written plan on what might occur and what to do.
   d. **Emergency Contacts** - Procedures are documented: numbers and names of who to call in an emergency, hospital preference, drug allergies, MediCal or other health insurance is on face sheet in job notebook and in client file. Also, client carries identification card, and documentation exists that he/she knows what to do in an emergency.

**INDIVIDUAL SERVICE PLAN**
1. **Plans Implemented for each ISP Objective**
   - Behavior and skills strategies described in ISP are currently being implemented. To score on PSR, list key word or phrase to denote ISP objectives (ex.: tenure, productivity, task, speed, breaks, grooming, purchase, bus). Under each, note + or “O”.
   2. a. **Protocol** - For each strategy, there is a written plan describing how it is implemented.
      b. **Data Sheet** - For each plan, there is corresponding data which is accurate, reliable, and updated at end of day or sooner.
      c. **Graph** - Generally, 1 per ISP objective, match objectives, current within one week, clearly labeled, accurate and reliable.
      d. **Reliability Checks** - At least quarterly, another staff observes client behaviors and services and takes data.
         1) **Interobserver** - Behaviors recorded match operational definitions - score is 85% or more reliability between two observers.
         2) **Procedural** - Procedures followed with protocol description - score is 85% or more.
      To score #2, list programs running by key word (ex.: work checklist, DRO, DRIP, PET, t.a.). Then mark + or “O” for a through d. For one program with multiple TA’s, can prorate.
   3. **Monthly Data Summary** - Sheet in job workbook summarizing monthly data for each ISP objective, updated by the 5th day of each month and accurate.
   4. **ISP Complete** - STEP ISP and quarterly (triannual) updates complete and timely (during client birth month, within 60 days of entering program, or by 10th of month after quarter (triannual period) ends.

**ADMINISTRATIVE**
1. **Client Case File** - File in central office neat, organized, and updated (include all necessary information such as STEP Intake Packet signed and completed, updated intake packet from Regional Center, case notes, earnings records, social security information, SIR’s, employer evaluations, STEP ISP’s)
2. **Job Notebook** - Job notebook accessible in field, neat, organized and updated (includes client identifying information, current data on ISP objectives, graphs, attendance, earnings, SIR forms). Follows Model Notebook Outline.
3. **Case Notes** - Anecdotal log notes about client progress, problems or concerns written once a week, then filed in Client Case File within 5 days of close of month.
4. **Employer Evaluation** - Client - Completed monthly by employer and discussed with client, then placed in Client Case File.
5. **Earnings** - Monthly earnings and hours recorded accurately on correct form and updated within one day. Earnings totaled at end of month, copies of pay checks included and turned in punctually on last day of month.
6. **TJTC/SSI** - Targeted Jobs Tax Credit forms filed in timely manner with receipt and interviews completed in timely fashion. Monthly paycheck information submitted to Social Security by end of month.
7. **Subminimum/Productivity** - State and federal subminimum wage certificate and renewals and required supporting documentation filed in timely manner (for new certificates, before job begins for federal and within 4 weeks for state). Productivity time and motion studies completed at least once every 6 months and wages paid are commensurate.

**STAFF DEVELOPMENT**
1. **CBT’s Complete** - Competency Based Training complete or prorated by tenure, seven during pre-training, one during each two subsequent weeks, 13 by three months, all by six months.
2. **Staff Meetings/Inservices** - Staff attends mandatory monthly staff meeting and quarterly inservice.
3. **Contact Meetings** - Staff attends weekly (or otherwise specified) meeting with contact person and follows through on recommendations.
4. **Employer Evaluations** - Staff scored 3’s and above on last evaluation by client employer and no major complaints since last check.
5. **Professionalism** - During spot check, staff appropriately attired for worksite, exhibits positive attitude, acts in accordance with client rights and client advocacy. To score + on this category, there must have been no major job site or supervisory problems or conflicts in this category between checks.
6. **Attendance/Punctuality** - Staff follows protocol for absences or lateness (i.e., appropriate notice so coverage can be arranged). To score +, arrived on time and attended work each day since last check (except for pre-specified time off or emergency).

After coding all items, count all +’s (and numbers on left side for prorated items) and write total under ‘Total +’s’. Then, count total possible and record. Divide total +’s by total possible for % score and note any comments in blank spaces.
1. Service Implementation
   a. Annual instructional plan. Annual instructional plan is complete and kept current.
      i. What: The annual individual instructional plan is complete and current (dated within one year of period of review).
      ii. Who: Service Manager
      iii. When: Ongoing.
      iv. How: Based on a review of a the consumer’s meeting schedule or meeting notes, a “+” is scored if the instructional team meetings were held weekly or bi-weekly according to the plan during the period of review.
   b. Service hours provided. Hours of service provided are no less than 90% of the number of hours authorized per month, given consumer’s availability for hours to be scheduled.
      i. What: Service hours are provided.
      ii. Who: Service Manager and/or Senior assigned to case.
      iii. When: Ongoing.
      iv. How: Based on a review of the consumer’s monthly treatment hours sheet, a “+” is scored if the total number of hours per week/month provided was at least 90% of the number of hours authorized given consumers’ availability for hours to be scheduled.
   c. Service notebook. Service notebook is in place, accessible to staff, complete, up-to-date and maintained at site.
      i. What: Service Notebook is maintained at site.
      ii. Who: Service Manager and/or Senior assigned to case.
      iii. When: Ongoing.
      iv. How: Based on a review of the consumer’s service notebook(s) during either a regularly scheduled site visit or at the instructional team meeting, a “+” is scored if the notebook is complete, up to date, and accessible to staff.
   d. Case file. Case file is in place, complete, up-to-date, and maintained at service office.
      i. What: Case file is maintained at the office.
      ii. Who: Service Manager.
      iii. When: Ongoing.
      iv. How: Based on a review of the consumer’s case file, a “+” is scored if an annual individual instructional plan is complete and current (dated within one year of period of review).
   e. Instructional team meetings. Supervisory meetings held weekly or bi-weekly (according to the plan) with the instructional team.
      i. What: Instructional team meetings are held.
      ii. Who: Service Manager and/or Senior assigned to case.
      iii. When: Ongoing.
      iv. How:
         a. Based on a review of the “People Present” section of the consumer’s instructional team meeting notes, at least one parent/guardian is present at all meetings during the period and/or has participated in scheduled appointments.
         b. Supervisory field visits have occurred for at least 2 hours per month at the primary service setting.
         c. Supervisory field visits have occurred for at least 2 hours per every 3 months at the non-primary service setting during the period, if applicable.
   f. Supervisory field visits. Supervisory field visits are conducted at primary setting for at least 2 hours per month and at least 2 hours every 3 months at non-primary setting.
      i. What: Supervisory field visits
      ii. Who: Service Manager.
      iii. When: Ongoing.
      iv. How: Based on a review of supervisory notes or schedule for the consumer, a “+” is scored if:
         a. Supervisory field visits have occurred for at least 2 hours per month at the primary service setting, and
         b. Supervisory field visits have occurred for at least 2 hours per every 3 months at the non-primary service setting during the period, if applicable.
   g. Parent participation. Parents, guardians, or responsible adult is present and participates as outlined in the service agreement.
      i. What: Parent Participation
      ii. Who: Service Manager.
      iii. When: Ongoing.
      iv. How: Based on a review of the “People Present” section of the consumer’s instructional team meeting notes, at least one parent/guardian is present at all meetings during the period and/or has participated in scheduled appointments.
   h. Instructional plan implemented. Instructional plan implemented as written at the 90% level.
      i. What: Instructional plan implemented
      ii. Who: Service Manager.
      iii. When: Ongoing.
      iv. How: Based on review of procedural reliability checks for that consumer during regularly scheduled field visits and review of case notes and data sheets, manager observes the plan being implemented as documented for at least 90% of established protocols.
   i. Instructional team meeting notes. Notes from the instructional team meeting are placed in the service notebook and provided to Service Manager.
      i. What: Instructional team meeting notes provided.
      ii. Who: Service Manager and/or Senior assigned to case.
iii. When: Ongoing.
iv. How: Based on a review of the consumer’s notebook, a “+” is scored if the notes from the previous two meetings are current and in place.

j. Field Based Quality Checks Field based quality checks meet the specified standard for critical and non-critical items.
i. What: Field Based Quality Checks
ii. Who: Service Manager or Senior
iii. When: Ongoing
iv. How: Based on a review of the consumer’s notebook, a “+” is scored if the notes from the previous two meetings are current and in place.

2. Outcome and Evaluation

a. Observational reliability checks. Observational reliability checks are accurate at an 85% or greater level.
i. What: Observational reliability checks
ii. Who: Service Manager or Senior
iii. When: Ongoing
iv. How: Based on a review of the observational reliability checklist completed during the review period, a “+” is scored if each score was 85% or higher.
b. Procedural reliability checks. Procedural reliability checks are accurate at an 85% or greater level.
i. What: Procedural reliability checks
ii. Who: Service Manager or Senior
iii. When: Ongoing
iv. How: Based on a review of the procedural reliability checklist completed during the review period for the consumer, a “+” is scored if each score was 85% or higher.
c. Goals and objectives met. Eighty percent of goals/objectives in instructional plans are met or are on target to be met based on quarterly progress report or data sheets.
i. What: Goal and objective met
ii. Who: Service Manager
iii. When: Ongoing
iv. How: Based on review of the consumer’s progress reports or data sheets, at least 80% of goals/objectives have been met or are on target to be met by established timelines.

3. Staff Training & Education

a. Completion of CBT modules. Direct staff complete seven CBT modules before beginning field training and all remaining required CBT modules by the end of their first three months.
i. What: Completion of CBT modules.
ii. Who: Service Manager
iii. When: First seven modules completed prior to beginning field training and remaining completed by the end of the first three months.
iv. How: Based on a review of the Staff Training Log, a “+” is scored if:
v. All staff assigned to that consumer, who began field training during the period of review, completed at least seven CBT modules prior to beginning field training, and
vi. All staff assigned to that consumer, reaching the end of their first three months of employment during the period, have completed the remaining required modules.

b. Field training. Direct staff demonstrate mastery of discrete trial teaching within no more than 50 hours of field training and prior to conducting sessions independently.
i. What: Mastery of discrete trial teaching.
ii. Who: Service Manager or Senior
iii. When: Mastery of discrete trial teaching is accomplished within 50 hours of field training and prior to conducting sessions independently.
v. How: Based on a review of the Staff Training Log and Field Based Quality Checklists, a “+” is scored if:

a. All staff assigned to the consumer who have completed a maximum of 50 hours of field training during the period are demonstrating competency to conduct sessions independently, and
b. All staff assigned to the consumer who began conducting sessions independently during the period demonstrated mastery of discrete trial teaching.

c. CPR and first aid training. Direct staff complete first aid and CPR training before conducting sessions independently.
i. What: CPR and first aid training.
ii. Who: Service Manager
iii. When: Training is completed prior to conducting sessions independently.
v. How: Based on a review of the Staff Training Log, a “+” is scored if all staff assigned to the consumer who began conducting sessions independently during the period of review have current first aid and adult and child CPR certification.
# GREENWICH PUBLIC SCHOOLS PERIODIC SERVICE REVIEW SCORING SHEET

**CLASS:** ____________________________  **TEACHER:** ____________________________

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## A. GENERAL COMPONENTS

1. Philosophy
2. Age Appropriate/Functional Curriculum

## B. ADMINISTRATIVE

1. Student Notebooks
2. Medical Records

## C. INDIVIDUAL SKILL PROGRAM

1. Working Notebooks
2. Schedule
3. IEP
4. ITP
5. Lesson Plans
6. Data
7. Data Summaries/Graphs
8. Progress Reports
9. Emergency Procedures
10. Reliability Checks
   a. Interobserver
   b. Procedural

## D. INDIVIDUAL BEHAVIOR PROGRAM

1. Assessment Reports/Intervention Plans
2. Behavior Protocol/Checklist
3. Raw Data
4. Reinforcement Charts
5. Program Implementation
6. Competing Contingencies Not Present
7. Data Summaries
   a. Charts
   b. Graphs
8. Reliability Checks
9. Emergency Procedures
10. Reliability Check
    a. Interobserver
    b. Procedural
**Class:** ________________________________________________  **Teacher:** ________________________________________________

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**Report Completed By:** ________________________________________________
PERIODIC SERVICE REVIEW
GREENWICH PUBLIC SCHOOLS
PREPARED BY: LORRAINE TERMINI

THE PERIODIC SERVICE REVIEW IS USED TO MEASURE THE OVERALL EFFECTIVENESS OF A SPECIAL EDUCATION PROGRAM. PROGRAM EFFECTIVENESS WILL BE MEASURED MONTHLY BY THIS CHECKLIST TO SEE IF STANDARDS ARE BEING MET. THE AREAS WHICH WILL BE LOOKED AT INCLUDE THE FOLLOWING:

A. GENERAL COMPONENTS
B. ADMINISTRATIVE
C. INDIVIDUAL SKILL PROGRAM
D. INDIVIDUAL BEHAVIOR PROGRAM
E. INSTRUCTION
F. STAFF DEVELOPMENT
G. FAMILY INVOLVEMENT
H. COORDINATION OF PROGRAM
I. STATUS REPORT DOCUMENT

A. GENERAL COMPONENTS:
   1. PHILOSOPHY: The philosophy of the program is stated in the students notebooks. The basis of the program is preparation for living, working, and enjoying life in an integrated environment.
   2. AGE APPROPRIATE AND FUNCTIONAL CURRICULUM: Spot checks done monthly to see that students are engaging in meaningful activities which are engaged by others of the same age. Checks also done to see if at least 20% of the curriculum is community based.

B. ADMINISTRATIVE
   1. STUDENT NOTEBOOKS: Each student has an up to date notebook which includes pertinent forms, schedules, current IEP and ITP, data forms, graphs, lesson plans, progress reports, behavior programs, emergency information, home/school communication and a table of contents.
   2. MEDICAL RECORDS: Are available and up to date in the school file located in the Guidance Office. The information must include the name of the medication, dosage, when and where it is taken and the possible side effects. Medication for seizures is also listed in the student’s working notebook.

C. INDIVIDUAL SKILL PROGRAM
   1. WORKING NOTEBOOKS: Each student has a working notebook located in the classroom and used by staff daily. It includes the following information: daily schedule, current IEP, lesson plans, data sheets and current behavior plan.
   2. SCHEDULE: Posted in the classroom is each student’s daily schedule and the student’s monitor for each period. The daily schedule should reflect scheduled lessons to be done that day.
   3. IEP: Each student has an updated IEP located in the student and working notebooks. The IEP includes:
      a. Identifying Information
      b. IEP Participants
      c. Present Functioning Level
      d. Goals
      e. Objectives
      f. Additional Information
   4. ITP: Each student age 15 and older in Special Education has an up to date ITP in the student notebook.
   5. LESSON PLANS: Each objective has an updated lesson plan located in the working notebook. The plan may include:
      a. Objective
      b. Discriminative Stimuli
      c. Prompt (Optional)
      d. Correct Response
      e. Consequence
         1. Correct Response
         2. Incorrect Response
      f. Inter-trial Interval
      g. Data Collection
      h. Program Change Criteria
         1. Pass
         2. Fail
      i. Special Criteria (if necessary)

6. DATA: Current data sheets are located in the working notebooks. Data is collected within 5 minutes of lesson each time that lesson is taught. Completed data sheets are located in the student’s notebook and past semester data sheets are located in the student’s file.

7. DATA SUMMARY/GRAPHS: Raw data is summarized daily on graph to see progress.

8. PROGRESS REPORTS: Quarterly progress reports are completed and located in the student’s notebook.

9. EMERGENCY PROCEDURES:
   a. When emergency intervention is used, it is documented and sent the appropriate supervisor.
   b. A written plan is in the student and working notebooks for any medical problems.
   c. Emergency information is in the student and working notebooks.

10. RELIABILITY CHECK: Done at least monthly for each student.
    a. Interobserver: Behaviors recorded match operational definitions - score is 85% or more. One skill each month is randomly selected for the check.
    b. Procedural: Procedures followed match protocol/task analysis description. Score is 85% or more. One skill each month is randomly selected for the check.

D. INDIVIDUAL BEHAVIOR PROGRAM
   1. ASSESSMENT REPORTS/INTERVENTION PLANS: For any existing program, there is a written assessment report and intervention plan following district protocols. Copies are located in the student notebook within 30 days of the start of the school year, the end of the quarter or upon the students enrollment. No aversives will be written into the plan.
   2. BEHAVIOR PROTOCOL AND CHECKLISTS: For each written intervention plan, there is a protocol and checklist in the working notebook.
   3. RAW DATA: Updated within 30 minutes.
   4. REINFORCEMENT CHARTS:
      a. CURRENCY: Updated within 30 minutes
      b. RELIABLE: Reinforcement charts cross check with data sheets.
   5. PROGRAM IMPLEMENTATION: Behavior programs described and planned are currently being implemented.
   6. COMPETING CONTINGENCIES NOT PRESENT: No other program implemented for target behaviors other than those in plans. (informal contracts, special deals)
G. FAMILY INVOLVEMENT

1. PPT: Families attend and are active participants during the development of the IEP. Questionnaires and rating scales are used to gather input from parents.

2. COMMUNICATION: At least weekly communication between staff and families via phone, notes, etc., as documented in the working notebooks.

3. MEETINGS: Scheduled parent meetings throughout the year dealing with pertinent issues. A minimum of 3 meetings per year as documented by minutes kept in a parent notebook.

4. PARENT COMMITTEE: Parents working with parents on issues they deem important. This is documented by formal notices and minutes kept in a parent notebook.

H. COORDINATION OF PROGRAM

1. ROLE: There is a written definition of each team members role. Copies are located in the Central Office and the classroom.

2. RESPONSIBILITY: Each role has a written list of responsibilities.

3. TEAM: Processes of team functioning is stated and followed. Copies are located in the Central Office and classroom.

I. PSR DOCUMENT:

1. EFFECTIVENESS: There is an annual check and review of the effectiveness of this document.

E. INSTRUCTION

1. INDIVIDUALIZED: Objectives are individualized on the IEP and lesson plans.

2. METHODS: Both one-to-one and group instruction are being used. Methods will vary depending on student and skill being taught.

3. ENVIRONMENTS: Direct training is occurring in actual situations in which target behaviors may occur.

4. COMMUNITY INSTRUCTION: For each student there is a minimum of 5 community based objectives.

5. COMMUNICATION: The classroom is communication based and communication skills are incorporated within each students lesson plans. The lessons are taught in real life situations rather than in isolated settings.

F. STAFF DEVELOPMENT

1. WORKSHOPS: Staff attends workshops and professional meetings pertinent to job duties within school system and out of district a minimum of 2 per year.

2. SCHEDULED STAFF MEETINGS: Staff attends monthly school based staff meetings as documented.

3. INSERVICE: Staff attends monthly special education meetings as documented.

4. TEAM INPUT: All objectives are developed by a team of people working with students which includes the teacher, assistants, speech therapist and senior teacher. Minutes of the meeting are kept.

5. CLASSROOM TEAM MEETINGS: Once a week meeting to address student and classroom needs. Minutes of the meeting are kept.

6. MAINSTREAM STAFF: By October 30th of each year, a presentation on people with disabilities is given to the mainstream staff. This is documented by the meeting agenda.

7. MAINSTREAM STUDENTS: By the spring of each year, a presentation on people with disabilities is given to the mainstream students. This is documented by presentation notes.

8. SPECIALIST: Once a year an outside specialist comes in to view the program. This is documented by a report.

7. DATA SUMMARIES:

   a. CHARTS: Raw data summarized on weekly chart. Current within 1 week and matches raw data sheets.
   b. GRAPHS: One for each target behavior identified in assessment reports and addendum. Current within 1 week, clearly labeled and matching weekly charts.

8. RELIABILITY CHECKS: Done at least monthly for each student.

   a. INTEROBSERVER: Behavior recorded match operational definitions. Score 85% or better.
   b. PROCEDURAL: Procedures match protocols in working book. Score is 85% or more.

9. EMERGENCY PROCEDURES:

   a. When emergency behavior intervention is necessary, a written plan is in the working notebook.
   b. When special incidents occur, it is documented and sent to appropriate supervisor.
   c. General emergency procedures are accessible to staff. All staff must initial that they have read the emergency procedures. The procedures must be followed correctly and use of such procedures are documented on raw data sheets. Incident reports as required.
Job
Performance
Standards
## BEHAVIORAL ASSESSMENT REPORT AND RECOMMENDED SUPPORT PLAN
### EVALUATION REVIEW CHECK LIST

Gary W. LaVigna, Ph.D., and Thomas J. Willis, Ph.D.

| Behavior Specialist ______________________ | Report Date ______________________ |
| Client Name ____________________________ | ID # _____________________________ |
| Reviewer’s Name ________________________ | Date of Review ____________________ |

### I. General Criteria

- **Format**
- **Identifying Information**

### II. Reason(s) for Referral

- **Source of Referral**
- **Key Social Agents**
- **Presenting Problems Described**
- **Referral Issues Discussed**

### III. Data Source

### IV. Description of Services

### V. Background Information

- **Brief Learner Description**
- **Living Arrangements**
- **Program Placement**
- **Health & Medical Status**
- **Previous or Current Treatment**

### VI. Functional Analysis of Presenting Problems

#### Problem #1:

- **Description of Referral Problems**
- **History of the Problem**
- **Ecological Analysis**
- **Antecedent Events**
- **Consequence Events**
- **Impressions of Analysis of Meaning**

#### Problem #2:

- **Description of Referral Problems**
- **History of the Problem**
- **Ecological Analysis**
- **Antecedent Events**
- **Consequence Events**

### Evaluation Criteria

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+ = Criteria Satisfied
O = Criteria not satisfied. Requires an instructional comment by the evaluator.
# Possible = Total number of criteria possible.
# Actual = Number of criteria satisfied.
I. General Criteria.
A. Format. Report is properly titled, is on formal letterhead stationery, uses appropriate type style, headings and margins, includes data of report (i.e., date final typed) and referral date (i.e., date referral was made from the referring agency). Period of service should also be shown incorporating the date the referral was given to the Behavioral Specialist and the date the report was submitted for typing. End of report should indicate the author’s name, title and affiliation.
B. Identifying Information. This section includes the person’s name, date of birth, ID# (if any), present address, and referral source. Optional information includes the names and relationships of the people the client is living with and an indication of the client’s program settings.

II. Reason(s) for Referral.
A. This should be a brief statement identifying the source of the referral and the specific behaviors precipitating it. Note should also be made of any special considerations regarding the motivation of the key social agents and how these relate to the referral problems. Additionally, any negative consequences threatened as a result of the behavior: e.g., physical damage to the learner and/or others, placement in a more restrictive setting, etc., should be noted.
B. This should be a brief statement of the key social agent’s reasons for requesting services. If the referral was made by an agency separate from the key social agent, some determination should be made concerning the agreement between them as to the reasons for the referral.

III. Data Source. This sections should identify and list the methods used in conducting the assessment. This could include direct observation, interviews, questionnaires, review of evaluation reports prepared by other professionals, previous program data, etc.

IV. Description of Services. This section should list the settings in which the assessment was carried out. Times and dates should be indicated. Also included should be telephone conferences, program development and report writing time.

V. Background Information.
A. Brief Learner Description. This should be a brief narrative description of client-identifying information such as age, sex, diagnosis, ability to comprehend and produce language, and any relevant results or informal testing that may have been reported by other professionals. Concrete descriptions and examples should be provided of client abilities and functioning level.
B. Living Arrangement. This should be a brief description of the learner’s current living arrangement indicating who she lives with, by name and relationship, the type of residence and the name, age and contact of any (other) family members who may have regular contact with the learner.
C. Program Placement. This should be a brief description of the learner’s present program placement(s) including location, name, type of program, evaluation of program, staff contact person, address, and phone number.
D. Health and Medical Status. This section should describe the general health of the learner, recent illnesses, operations, seizure activity, type of seizure, blank or staring spells, etc. It should also indicate frequency of seizures, most recent seizures, treatment for seizures, what medication or drugs the learner is presently taking and for what purpose.
E. Previous or Current Treatment. This section should describe any previous attempts to treat the current problems and the outcome of those efforts. This should include, for example, information concerning where, whom and for what reason there were any inpatient referrals, and a brief description of previous behavioral intervention programs. Previous interventions should be described in sufficient detail as to allow for an evaluation of design and an evaluation of procedural reliability.

VI. Functional Analysis of Presenting Problem(s)
A. Description of Referral Problems. Each behavior should be defined to include topography, cycle course and measures of severity. Present rate and severity measures or best estimates should be reported.
B. History of the Problem. The onset and duration of the current problems should be indicated. Any recent increases or decreases in the behavior should be indicated. In addition, indications and/or speculations should be reported regarding any events that may have contributed to an exacerbation of the problem(s).
C. Ecological Analysis. This section should describe the system that surrounds the target behavior, including the physical characteristics of the environment, the social system and opportunities for interpersonal interaction, and program characteristics.
Factors to consider when conducting an ecological analysis should include, but are not necessarily limited to:
1. The learner’s expectations about the environment
2. The expectations of others in the environment concerning the learner.
3. The nature of the materials and physical objects available to the learner.
4. The reinforcement and preference value of the materials/objects available.
5. The nature of the activities in which the learner is engaged in terms of difficulty, interest level, etc.
6. The number of people present in the learner’s environment.
7. The behavior the other people in the learner’s environment.
8. Environmental pollutants such as noise, crowding, etc.
9. Sudden changes in the learner’s life, environment or reinforcement schedule.
10. Individual abilities such as general skills, communication skills, and adaptive ability, as they relate to the demands of the environment.
11. The level of program difficulty.
12. The effectiveness of available reinforcers.
13. The variety of materials/activities available.
14. The variety of groupings arrangements used.
15. The opportunities for interaction with others, including individuals who are not disabled.
16. The variety and nature of settings to which the learner has regular access.
17. The nature of instructional strategies used in programming.
D. Antecedent Events. Specific antecedents which typically precede the problem behaviors should be described. This should include consideration of specific activities, time
VII. Motivational Analysis. This section should identify and prioritize potential positive reinforcers for the learner. Included should be predictably occurring behaviors, likes and dislikes, and verbal requests. Satiation levels should be indicated and/or further assessment in this area should be described and recommended.

VIII. Mediator Analysis. This section should describe the strengths and weaknesses of the parents, teachers and other key social agents who would act or who may act as mediators of the programs. Their strengths and weaknesses should be described as well as the potential effects of these on the course of intervention. A realistic estimate should be made of the mediators' ability to carry out programs given the demands on time, energy, emotions, and the constraints imposed by the specific program settings. If different or additional resources are needed in this area, they should be described.

IX. Recommended Support Plan.
A. Long-Range Goals. This section should describe the long-range goals for intervention in terms of clinical outcome, i.e., quality of life measures.
B. Short-Term Behavioral Objectives. This section should indicate time limited measurable objectives for each of the referral problems and targets of the intervention and positive program. Specifically, in regard to the referral problems, this should indicate in quantitative terms the changes that are being targeted in comparison to baseline levels and when those targets are expected to be reached. Measurable objectives should also be established for durability, generalization, side effects and social validity.
C. Data Collection. The procedures and forms to be used for data collection should be described for each of the short-term objectives. The methods used to ensure the reliability of observations should also be described, if applicable.
D. Intervention Procedures.
   1. Ecological Manipulations. Specific recommendations should be made for alterations to the learner's physical, programmatic and/or interpersonal environments for the purpose of providing the most support for achieving the overall treatment goals and objectives.
2. Positive Programming. Specific and systematic instructional programs should be described to develop:
   a. General Skills - in the areas of domestic, vocational and general community functioning. The tasks and activities should be directly functional, chronologically age-appropriate and performed in socially integrated community settings.
   b. Functionally Equivalent Skills - in an effort to give the learner more effective and socially acceptable ways of addressing the functions identified for the targeted problem behaviors.
   c. Functionally Related Skills - in an effort to provide the learner with those critical skills that are related to but that do not directly serve the same functions identified for the problem behaviors.
   d. Coping Skills - to increase the learner's ability to tolerate unavoidable, naturally occurring aversive events, particularly those identified as discriminative for problem behavior.
3. Direct Treatment. Specific intervention strategies should be prescribed with the objective of producing the most rapid reduction in problem behavior, in a manner consistent with the overall treatment goals and objectives.
4. Reactive Strategies. Specific recommendations should be made for the situational management of behavioral episodes in a manner consistent with IABA's Emergency Management Guidelines.
5. Staff Development. This section should describe any possible staff training that would facilitate the delivery of the program described above.

X. Comments and Recommendations.
A. Any difficulties that may be anticipated in the proposed intervention should be described.
B. Additional resources or services that may be available and helpful to the key social agents in carrying out the program should be specified. If services are being recommended, the number of hours should be specified as well as specific expectations concerning the future fading of these services.
C. Strategies for evaluating future fading should be described (e.g., quarterly).
Reliability Checks and Monitoring Aids
**Interobserver Reliability**

Client: _____________________________________________  Behavior: ___________________________________________

Instruction: Observations should be done for one hour using identical data collection sheets. At the end of the hour, primary and secondary observers’ scores are compared according to the following formula:

\[
\frac{\text{Smaller frequency/duration}}{\text{larger frequency/duration}} \times 100 = \text{Reliability Index}
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Record score (according to client and behavior stated above) and other information below:

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Behavioral Protocol and Checklist #2 (of 4)

Client’s Name: Steven
Intervention Program Name: DRL (absence of Teasing)
Locator: IABA® #1A

Target Behavior and Definition:

Teasing: This is defined as mimicking others’ behavior, clicking his fingers, clapping his hands behind others, getting into others’ belongings, getting too close to peers’ or staffs’ faces, or annoying others in any other way. Each new episode is separated by five minutes without the behavior.

Data Collection Methods:

1. Record incidents of Teasing according to the operational definition above.
   a. Use prepared data frequency sheet on general client clipboard.
   b. Record all incidents which occur throughout the program day.
   c. Record immediately (or as soon as possible) after the behavior occurs.

Data Summary Methods:

1. On a daily basis, transfer to “Data Summary Sheet” incidents of Teasing. This will be done by the programmer or supervisor.
2. Tally weekly and monthly and include average daily rates. This will be done by the House Supervisor.
3. Graphing of incidents of Teasing will be done by House Supervisor.
4. Graphing will be cumulative, abscissa limits are 6 months by days, ordinate limits are 0 -100%

Intervention Procedure

Procedure # DRL - (Differential Reinforcement of Low Rates of Responding) for Teasing.

1. Intervals. This procedure will be carried out throughout for one daily interval (wake-up to bed).

Changes: Dates:

2. Self-Employed Tangible Monitoring System. There will be two cups on the board along with three possible sticks. The moving of a stick from cup #1 to cup #2 will symbolize an incident of teasing.

3. Reinforcers. At the end of each interval, Steven will earn a soda.
**Verbal Reliability Checklist**

**Definition:**
- Identifies target behavior(s)
- Clearly defines target behavior(s)
- Identifies onset/offset times

**Data Collection:**
- Identifies what to record
- Identifies where recording takes place
- Identifies types of antecedents that are to be written on ABC sheet

**Reinforcement:**
- Identifies when to reinforce (i.e., intervals)
- Identifies what reinforcer is to be given
- Identifies how to deliver reinforcer
- Describes what is said to client when delivering reinforcers
- Verbalizes reinforcer exclusivity rule

**Prompting:**
- Describes prompt to be used
- Identifies when prompt is to be given

**Target Behavior Occurrence**
- Describes intervention beginning of response chain
- Describes prompting procedure to be used
- Describes how to use active listening
- Describes how to use contingent relaxation procedures
- Describes what emergency methods could be used
- Describes need for Special Incident Report

**Total Score Achieved**

**Total Score Possible**

**Percent Reliability**

---

Name of Client: ____________________________

Program: ________________________________

Staff Person: ____________________________

Date: ________________________________
PROCEDURE RELIABILITY

Client: Steven Program DRL  Target Behavior: Teasing

Staff Observed ________________________________ Date ________________________________

1. Staff records Teasing Behavior immediately. Yes No
2. Staff Records Teasing Behavior on correct form. Yes No
3. The Behavior Staff records and consequated falls within the correct definition of teasing. Yes No
4. Staff records correct number of episodes of teasing according to movement cycle. Yes No
5. Staff prompts Steven to the reinforcement board. Yes No
6. Contingent upon occurrence of teasing, staff labels the behavior for Steven. Yes No
7. Staff encourages Steven to move one stick from Cup 1 to Cup 2. Yes No
8. Staff informs Steven that he teased another resident and therefore has to move one stick to cup two. Yes No
9. Staff reminds Steven he has “X” sticks left and that he needs one left in order to earn his soda. Yes No
10. Staff reinforces Steven periodically for leaving appropriate peer relations. Yes No
11. At the end of the interval (bedtime) staff prompts Steven to the board again. Yes No
12. Staff informs Steven that he has at least one stick left in the cup, one stick and he earns his soda for working to control his teasing. Yes No
13. Staff enthusiastically enforces Steven with praise and delivers a soda to him. Yes No
14. Staff reminds Steven of his contract tomorrow. Yes No
15. If Steven does not have any sticks left in Cup 1, staff informs Steven that he does not earn his soda. Staff also reminds him that he needs to work harder on not teasing tomorrow in order to earn his soda. Yes No
16. Staff recycles the teasing sticks at the end of the interval. Yes No
### Behavioral Services Competency Checklist

V - Staff Correctly Verbalizes Program Components
S - Staff Correctly Role-Plays Program in Simulated Situations
R - Procedural Reliability on Program Implementation (90% or above)
O - Interobserver Reliability on Data Collection (90% or above)

+ = Meets Competency
O = Does Not Meet Competency

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Placheck

Planned Activity Checklist

Doke and Risley, 1972

1. Define behavior or target performance.
2. Record, at given interval, total # of individuals engaged in the target performance.
3. Record total # of individuals present in area of activity.
4. Compute a percentage:

\[
\frac{\text{# of individuals engaged in target performance}}{\text{Total # of individuals in environment}} \times 100
\]
Feedback and Contingencies
**Pay for Performance**

Thomas Rollins

**Cons:**

1. Tying cash incentive to a task diminishes the attractiveness of that task.

2. It is difficult to make fine distinctions of reliability among performance levels of many of the staff.

3. Any system that divides resources based upon superior’s rankings of merits will be regarded as unfair by staff.

4. Staff prefer security and guarantee of automatic tenure based step increases in pay.

5. Managers/Supervisors will take easy way out and staff about the same increase.

6. Budgeting cycle of most large companies is so far ahead of the fact that true pay for performance may be impractical.

7. Immediacy test for motivation is hard to satisfy when most company pay incentives or adjust salaries only once a year.


9. The need to generate tailored goals and measures that go beyond budget numbers exceeds the capacity of most organizations to digest and manage.

10. Staff view pay for performance not as a way of stimulating performance but as a way to contain compensation.

**Pros:**

1. Can serve as effective motivator inherent performance.

2. Superior staff resent automatic and indiscriminate pay increases for all.

3. Tying pay to performance puts teeth in the performance monitoring process.

4. Good pay for performance programs increases the clarity of staff goals

5. Pay for performance programs give and give all organizations much greater mileage on their compensation dollars.

6. Good pay for performance programs increase staff’s sense of ownership and involvement in the overall company performance.

7. Installation of a pay for performance program can help start a process of cultural change.

8. Pay for performance systems are conducive to “no surprise” policy of performance evaluation.

9. Pay for performance programs encourage staff to track their own performance against pre-established targets - thus creating a sense of challenge to improve level of work efficiency.

10. Good pay for performance programs decrease subjectivity of the performance process.

**Reinforcers**

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<th>Social:</th>
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<td>Verbal praise</td>
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<td>Special job title</td>
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<td>Recognition in front of co-workers</td>
<td>Special badges or insignias</td>
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<td>Notes of thanks</td>
<td>Raises/bonuses</td>
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<td>Picture in company paper</td>
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<td>Pats on the back</td>
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<td>Greetings from boss</td>
<td>Free tickets to sporting events</td>
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<td>No-punch lunch</td>
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<td>Birthday off</td>
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<td>Longer coffee breaks</td>
<td>Chances to win prize (lottery)</td>
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<td>Flexible work schedule</td>
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<td>Training for better job</td>
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Workshop Exercises
Work Performance Standards

Workshop Exercise

A. Select five performance areas of specific responsibilities that you would like to improve.

B. Operationally define each action you would like to be performed, or each responsibility according to the following guidelines:

1. Specify exactly **WHAT** you want staff to do or the responsibility you would like them to perform in **OBSERVABLE** terms.

2. Specify exactly **WHEN** you want the action to be carried out (i.e., Timelines)

3. Specify **WHO** has the responsibility for carrying out the action.

4. Specify **HOW** (Verifiability) you will know the action has been carried out (e.g., direct observation, record review).

C. Practice Standard 1:

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E. Practice Standard 3:
1. Specify exactly **WHAT** you want staff to do or the responsibility you would like them to perform in **OBSERVABLE** terms.

2. Specify exactly **WHEN** you want the action to be carried out (i.e., Timelines)

3. Specify **WHO** has the responsibility for carrying out the action.

4. Specify **HOW** (Verifiability) you will know the action has been carried out (e.g., direct observation, record review).

F. Practice Standard 4:

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Assuring Staff Consistency Bibliography


Langeland, K., Johnson, C., & Mawhinney, T. (1998). Improving staff performance in a community mental health setting: Job analysis,
training, goal setting, feedback, and years of data. Journal of Organizational Behavior Management, 18, 21-43


ePSR.com

For automated charting and analysis of PSR data
Section Two

Test Questions and Answers

These test questions may be individually administered and scored at after a person has viewed a Module or they may be used by the group leader as discussion questions for group discussion.

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(Permission is granted to make copies of these questions for use with the video training program “Positive Practices in Behavioral Support.”)
Module 1 Test Questions

1. Punishment Results in:
   b. A future increase in response strength.
   c. Both a and b.
   d. None of the above.

2. What statements are true about aversive events:
   a. They are stimuli or events that people would normally act to avoid.
   b. They can always be considered as punishment.
   c. Both a and b.
   d. None of the above

3. Which of the following does not measure effectiveness:
   a. Rapid control
   b. Social and clinical validity
   c. Inter-observer reliability
   d. Durability and Generalization

4. Which of these elements is NOT a part of the IABA multielement framework
   a. Mediation
   b. Progressive Discipline
   c. Assessment
   d. Support Plan

5. Ecological Strategies focus solely on physical factors
   a. True
   b. False

6. Crowding is always an ecological mismatch
   a. True
   b. False

7. The purpose of Positive Programming is to
   a. Reinforce positive behavior
   b. Manage emergencies
   c. Teach skills and competencies to the consumer
   d. Assess the function of behavior

8. For a fixed-interval DRO, the reinforcement interval should be
   a. 50% of the average time between responses before intervention
   b. As frequently as the behavior occurs
   c. 10% of the average time between responses before intervention
   d. 75% of the average time between responses before intervention
9. Which of the following is NOT a way to minimize the potential for aversive components in a DRL reinforcement system?
   a. Be matter of fact
   b. Use the threat of losing reinforcement as a way to stop a behavior
   c. Link failure with opportunity
   d. Do not use markers as exchangeable tokens.

10. Which of the following pairings best satisfies the 100% rule?
    a. Being in seat/being out of seat
    b. Verbally expressing frustration/physical aggression
    c. Head banging/Not Head banging
    d. Writing in a journal/Profanity

11. In column A, there are listed 4 types of skills. In column B are 4 examples. Match the examples with the skills in column A by writing the letter of the example in column B next to the matching skill in column A.

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<th>B</th>
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<tr>
<td>1. General Skills</td>
<td>a. Skills that replace undesirable behaviors while meeting the same needs as those behaviors</td>
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<td>2. Functionally Equivalent Skills</td>
<td>b. Skills that teach a person to tolerate naturally occurring aversive events</td>
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<tr>
<td>3. Functionally Related Skills</td>
<td>c. Include domestic, self-care, recreational, community, vocational and academic skills</td>
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<td>4. Coping and Tolerance Skills</td>
<td>d. Skills that can reduce the likelihood of behavior, but are not directly related to the behavior</td>
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12. Focused Support Strategies
   a. Teach a person how to tolerate aversive events
   b. Only consist of reinforcement strategies
   c. Reduce, and if possible, eliminate, the need for a reactive strategy.
   d. Produce durable changes in behavior.
1. Which of the following is NOT a component of a FUNCTIONAL ANALYSIS?
   a. Analysis of the problem behavior
   b. Analysis of the history of the problem
   c. Neurological examination
   d. Consequence Analysis

2. Circle all of the methods used to gather information
   a. Observation
   b. Records Reviews
   c. Interactions
   d. Contemplation

3. Description of the Problem Behavior includes
   a. Identification of the topography, cycle, course, and strength of the behavior
   b. Identification of the topography, antecedents, and consequences of the behavior
   c. Identification of the behavior, history, and antecedents of the behavior
   d. None of the above

4. The Topography of behavior is a description of:
   a. the onset and offset of the behavior
   b. the precursors to the behavior
   c. the physical characteristics of the behavior
   d. the strength of the behavior

5. Which of the following is a true statement about a Functional Assessment?
   a. Knowing the history of the behavior may help determine whether behavior intervention is appropriate
   b. Identification of the antecedents to the problem behavior, the behavior itself, and the consequences of the behavior are only part of a functional assessment
   c. A functional assessment attempts to determine WHY the behavior occurs.
   d. All of the above
   e. None of the above

6. Bill hits others and throws objects when he is criticized. Staff decide to avoid all criticism as a first step in treatment. This is an example of:
   a. Establishing Stimulus Control
   b. Stimulus Satiation
   c. Antecedent Control
   d. DRO
1. Which of the following statements is true of reactive strategies:
   a. Reactive strategies should be selected for their primary role of situational management, in a way that minimizes the risk to injury to the client and those around him.
   b. In selecting a reactive strategy, a primary concern is to avoid reinforcing the behavior.
   c. Reactive strategies typically teach skills.
   d. Episodic severity measures are not used to determine the effectiveness of reactive strategies.

2. Mark the one item below that best describes the way to deal with staff feelings about a client and the targeted behavior problem.
   a. Staff should be able to “turn off” their feelings while working.
   b. Staff should always let their clients know if their challenging behavior upsets them.
   c. Staff should be given regular opportunities to express their feelings and help in developing strategies for dealing with them.

3. What statement is most true about the role of natural consequences in an intervention plan:
   a. They should be avoided if at all possible, since people with learning difficulties are not as likely to learn from natural consequences.
   b. Staff should attempt to utilize natural consequences as a way to help deal with their own feelings during an incident.
   c. Natural consequences are rarely aversive.
   d. Natural consequences never interfere with integration of an individual into the community.

4. What part of the Comprehensive Functional Assessment describes precursors?
   a. History of the problem
   b. Course description
   c. Consequence Analysis
   d. Analysis of Meaning

5. What is staff’s primary role during the recovery phase?
   a. Instruct the client about what they did wrong, and how to prevent it from occurring again.
   b. To direct the client to restore the environment and/or apologize to anyone who was hurt.
   c. To remind the client that reinforcement will not be earned.
   d. Not to re-ignite the crisis.
6. During an episode of aggressive behavior, a staff member working with the client stops the client's behavior by running in a circle while clucking like a chicken. What is the name of the technique that was used to resolve the behavior?

   a. Stimulus Change
   b. Active Listening
   c. Geographical Containment
   d. Antecedent Control

7. What prevents strategic capitulation from reinforcing target behavior?

   a. Giving frequent, non-contingent access to the identified reinforcer
   b. Having a high density of preferred events in the person's life.
   c. The utilization of a multi-element support plan.
   d. All of the above

8. Which of the following is an important guideline in the use of strategic capitulation?

   a. Don't use it if you think it will reinforce the behavior.
   b. Don't provide other opportunities for reinforcement.
   c. Use it as early as possible during the escalation phase.
   d. All of the above.
Module 4 Test Questions

1. What has research identified as the #1 reason for poor performance in the workplace?
   a. Poor management practice
   b. Lack of training
   c. Low wages
   d. Lack of resources

2. Which of the following is not a necessary element of an effective staff management system?
   a. Defining performance responsibilities
   b. Changing performance
   c. Progressive Discipline
   d. Teaching skills to staff

3. What of the following is NOT TRUE about Performance Standards?
   a. They provide a basis for training staff.
   b. Having standards is all that is necessary for a Periodic Service Review.
   c. Standards are defined as the specification and operationalized definition of staff responsibilities
   d. They can be classified as Process or Outcome.

4. To produce effective outcomes, how often should PSR sessions be held?
   a. Once per quarter
   b. Twice per year, as part of the client’s annual and semi-annual review
   c. Once per year
   d. No less than monthly.

5. What is one way to increase staff acceptance of the PSR system?
   a. Tie PSR scores to performance reviews
   b. Involve staff in the development of standards
   c. Have management develop standards independently
   d. Have staff develop all standards on their own

6. Which of the following is NOT a basic principle in the use of visual feedback?
   a. Graphs should be posted in areas visible to staff.
   b. Graphs should identify the performance of individual staff
   c. Graphs should be used as a basis for competition
   d. Graphs should represent the performance of single job category
# Test Answers

**Module 1**

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Section Three

Article Reprints

The following four articles will enhance your understanding of the material presented in the DVD Lectures. These should be made available to all viewers.

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Challenging Behavior: A Model for Breaking the Barriers to Social and Community Integration

Gary W. LaVigna and Thomas J. Willis
Institute for Applied Behavior Analysis, Los Angeles, CA

A version of this paper was presented at the Annual Conference of the Association for Behavior Analysis, San Francisco, CA, May, 1992.

A major value associated with the recent movement toward community integration for people with a developmental disability has been the opportunity for social integration and interaction with the general population. Major barriers remain, however, for those disabled individuals who exhibit significant challenging behavior. These barriers may include both the behavior challenges the person presents as well as the support strategies that have traditionally been employed to remediate the challenges. They are barriers because neither may be accepted by society—thus limiting the person’s opportunity to benefit from the community integration movement. Present models for providing support have not proven fully adequate to the task of breaking these barriers to social and community integration for individuals who have severe and challenging behavior. In the following paragraphs, we present a model of support that we feel may go a long way toward “Breaking the Barriers.”

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Outcomes

The foundation of the model is an expanded view of the outcome criteria by which support strategies can be evaluated (see Figure 1 on page 10). Traditionally, the success of a support plan has been measured by how quick and how much the plan has reduced problem behavior (i.e., the speed and degree of effects). We suggest that you must go beyond simple speed and degree of effects to conclude that a support plan has been effective. Support strategies should be evaluated in terms of the durability and generalization of their effects, the side effects they produce, and their social and clinical/educational validity (Favell et al., 1982; Evans & Meyers, 1985). This last outcome requirement is perhaps the most important, for it keeps us focused on the major point of a support plan. That is, not to eliminate the target behavior, per se, but to contribute to the overall quality of the person’s life. This most critical measure...
Continued from page 1

sure says that a support plan has clinical/educational validity if, as a result and through the process of bringing the behavior itself under control, the person has a better quality of life, that the person has such things as more access, opportunity, choice and control, competencies and nurturing, caring and mutually gratifying relationships.

This complex array of critical outcomes makes it unlikely that any one strategy will produce all the desired results. Rather, full results are likely to require multielement support plans whose various components, in combination, address the full range of outcome requirements.

Support Plans

Proactive Strategies

The components of our multielement support plan are illustrated in Figure 1. The first major distinction within a multielement support plan is between proactive strategies and reactive strategies. Proactive strategies are those designed to produce changes over time. Reactive strategies, on the other hand, are those designed to manage the behavior at the time it occurs. Included within the category of proactive strategies are ecological changes, positive programming, and focused support. These three categories of proactive strategies, and their intended contributions to outcomes, are described below:

Ecological Changes. As the ABA Task Force report on “the right to effective treatment” acknowledges (Van Houten et al., 1988), behaviors occur within a context and often are a function of the person’s physical, interpersonal and programmatic environment. Environmental or setting events and characteristics (i.e., the ecological context for behavior) provide an important area of analysis and offer significant opportunities for change as part of a support plan. For instance, some challenging behaviors could be a reaction to the crowded or noisy conditions in which a
person must work, or could be a reflection of simple boredom. If this is the case, then the challenging behavior may be impacted by simple ecological changes in which crowding and noise are reduced and the environment is made more exciting. Some examples of ecological changes include changing the person’s setting (Horner, 1980); changing the number and quality of interactions (Egel, Richman & Koegel, 1981; Strain, 1983); changing the instructional methods that are being used (Koegel, Dunlap & Dyer, 1980; Winterling & Dunlap, 1987); changing instructional goals; and/or removing or controlling environmental pollutants such as noise or crowding (Adams, Tallon & Stangle, 1980; Rago, Parker & Cleland, 1978). Generally speaking, ecological changes attempt to “smooth the fit” between the person and his or her environment by modifying the environment (Rhodes, 1967).

Behavior challenges may reflect a poor match, i.e., a conflict between the person’s needs, characteristics and aspirations and that person’s physical, interpersonal and programmatic environments. Resolution of those conflicts may require a change in those environments. For example, if the assessment concludes that the challenging behavior is a reaction to a barren and unstimulating living environment, it may ultimately be necessary for that person to have a home that provides more stimulation.

This may take some time, however. In the meantime, while a more suitable living arrangement is being pursued, strategies may be needed to reduce or manage the challenging behavior in the current location. Focused support strategies are designed to meet this need. The person may be reinforced for the absence or lesser occurrence of the problem; antecedents that set off the behavior may be eliminated to reduce the likelihood of the behavior (i.e., antecedent control strategies may be employed); etc.

Ecological changes do not always produce an immediate improvement in behavior. For example, while most individuals might show improvement in moving from an institutional setting into the community, some might show an increase in challenging behavior. Such an environmental change might still be pursued, however, if it is in a normal home environment that the person can learn, through positive programming, to be successful and enjoy living in a real home. If such a goal has to make increasingly informed choices?

The following anecdote shows how one support team struck this balance.

A young, adult man with the challenges associated with autism engaged in frequent self injurious behavior. Assessment and analysis disclosed that most of this behavior was his way of saying “no,” his way of saying that he didn’t want to do what he was being asked to do. Accordingly, his support staff developed a positive program to teach him how to say “no” by holding up a wooden symbol. The instructional program was successful and self injury was avoided by staff backing off from their request whenever he held up the symbol. The quandary that they found themselves in, however, was that, in this fashion, he avoided most opportunities to learn new skills, even a recreational skill such as ping pong and the like. Whenever staff would begin instruction, he would “choose” not to participate by holding up his signal.

In response to these circumstances, staff then developed another positive program to teach coping and tolerance for this activity. They initially withheld the availability of the wooden “escape” symbol for a few seconds. This delay was not long enough to provoke an episode of self injury, but it did allow some initial seconds of instruction. When the symbol was available and held up by the person, staff responded by terminating the activity. Very gradually, the availability of the symbol was delayed for increasingly longer periods of time, still with self injury being avoided. This continued until the availability of the symbol was being delayed for a five minute period of instruction. This was accomplished while still avoiding self injury.

At this point, the symbol was made available from the beginning of instruction. It was observed that this young man would tolerate 30 seconds of ping pong instruction before he asked to stop, using his wooden symbol. Staff always complied with this request by terminat-
ing the instructional session. However, for any session that lasted for 30 seconds or less, they terminated the session with a sincere “...Nice game. Let’s play again tomorrow.” For any session that lasted for more than 30 seconds, they terminated the session with “...Nice game. Let’s play again tomorrow. Why don’t we go get a snack.” Through this differential reinforcement, and with a gradual increase in the criterion for reinforcement, this young man eventually got to the point where he could volley back and forth a 100 times, successfully, missing no more frequently than his opponent. More to the point, he began to seek staff out with the ping pong paddles in an effort to get them to play with him.

This example provides one illustration of how staff balanced the important ecological strategy of increasing a person’s choice and control with a positive program teaching tolerance for learning a new recreational skill. This was accomplished in such a way that challenging behavior was brought under control while enriching the person’s quality of life, by giving him a new recreational skill that he now has the opportunity to enjoy on a regular basis. The model reminds us that ecological strategies hold a position of primacy in
our support plans, but that these strategies may need to be balanced by the other strategies to produce outcomes that have the highest clinical/educational validity, that is, result in the best quality of life possible for the person.

**Positive Programming.** If Ecological changes can be described as changes in the environmental context, to smooth the fit between the environment and the individual, positive programming can be described as changes in the person’s skills to deal better with the environment. Positive programming is defined as systematic instruction designed to give the individual greater skills and competencies which will contribute to social integration (LaVigna, Willis and Donnellan, 1989). There are four variations of positive programming involving the development of general, functionally equivalent, functionally related and coping/tolerance skills.

**General skill development** across the domestic, vocational, recreational, and general community domains facilitates the reduction of challenging behavior by increasing the person’s repertoire of socially acceptable responses. “The increase in more adaptive and socially adequate behaviors will no doubt result in a concurrent decrease in maladaptive behaviors” (Lovaas & Favell, 1987, p. 312) (e.g., Wong et al., 1987). The opportunity to learn and engage in a wide variety of activities thereby provides a fundamental basis for other instructional efforts.

Challenging behavior occurs in certain situations because they can serve useful functions (Carr & Durand, 1985; Durand, 1990). What is much needed is an analysis of these functions and the incorporation of positive programming which teaches functionally equivalent but more socially acceptable responses, or responses that are otherwise functionally related to the identified reinforcers. (Donnellan, Mirenda, Mesaros, and Fassbender, 1984; Favell, McGimsey & Schell, 1982).

Along with ecological change, positive programming has the primary goal of producing durable, generalized outcomes, with good social and clinical/educational validity. In contrast with ecological change, positive programming involves systematic instruction while the former has to do with availability and opportunity. For example, ecological change could involve having access to a kitchen in one’s home, having choices about what to do and having a day planner in which to schedule one’s day. Positive programming might include teaching the person how to cook a meal independently, teaching the person how to make choices and teaching the person how to use a day planner to schedule a full day of interesting and desirable activities.

LaVigna, Willis and Donnellan (1989) describe in more detail the different variations of positive programming. We believe that among the most important functionally related skills is the ability to cope with and tolerate naturally occurring aversive events. This last category of positive programming deserves to be highlighted because it is often overlooked in support plans and because of its critical need for anyone who is living a full life in the real world.

Life’s texture includes being told such things as “later,” “no,” and “good-bye.” It includes such things as failure, frustration, criticism, being teased, being sick and performing nonpreferred tasks. While we would want to help anybody find a set of life circumstances that keeps these naturally occurring events to a minimum, anybody who has a life, has these experiences.

The rub is that these events are often the antecedents to challenging behavior. Ecologically, we may try to minimize them and it may be important to teach the person to learn how to communicate the key messages that let us know what she or he wants or what he or she is upset about. For truly durable outcomes, however, and for the best quality of life possible, support staff may need to take the responsibility to systematically teach the person how to cope with and tolerate these events, and positive programming may require some time before new skills and competencies are mastered. It may therefore be necessary to include focused support strategies for more rapid effects. Hence the inclusion of these strategies in our approach (see Figure 1).

There are alternatives to punishment in addition to differential schedules of reinforcement which can produce this rapid effect (LaVigna and Donnellan, 1986). These include, but are not limited to, certain antecedent and instructional control strategies (Touchette et al., 1985; Touchette, 1983; Carr, Newsom, & Binkoff, 1976) and stimulussatiation Rast, Johnston, Drum, & Conrin, 1981; Ayllon, 1963). A comprehensive support plan could also include nonbehavioral strategies such as neurophysiological techniques, medication adjustments, and dietary changes.

Within the multielement model, the purpose of a focused support strategy is to produce the most rapid effects possible, to reduce the risks associated with the behavior and to reduce the need for reactive strategies. The model emphasizes the use of nonaversive focused support strategies, since punishment
brings a greater risk of negative side effects and itself may detract significantly from the person’s quality of life. Further, the use of some punishment procedures may preclude the person from having access to certain environments, because of the relative lack of free from the risks associated with the challenging behavior, including the risk of further exclusion. This “anti-technology” sentiment may be understood within the context of a history in which many believe “behavior modification” has been used with a behavior, program or research focus rather than a focus on the person and her or his quality of life. However, this framework proposes to harness behavioral technology toward the end of supporting human values and dignity. (See the discussion of clinical/educational validity elsewhere in this article.)

A person who is physically challenged may need a physical prosthesis, such as a wheelchair, to gain independence and full community access. Support staff would advocate for the individual’s right to the wheelchair, even though it may represent an “artificial” means by which the person would have mobility in the community, and may in fact elicit negative attention from the community. Similarly, a person who is behaviorally challenged may need a behavioral prosthesis, such as a formal schedule of reinforcement, to gain temporary control over behavior and to enjoy full community presence and participation, as more permanent solutions are being sought. This would suggest that support staff should be equally comfortable in advocating for the individual’s right to the schedule of reinforcement, if needed, even though it may represent an “artificial” means of behavior control, and may in fact elicit negative attention from the community.

To summarize, proactive support strategies are included for the narrow array of desired outcomes. While proactive support strategies are included to produce changes over time, reactive strategies are included for the narrow but important purpose of situational management.

**Reactive Strategies**

The need for situational management is unavoidable when you are supporting a person whose behavior can be challenging. For those support staff who have been resistant to using strictly non-punitive strategies, it may be partly because many advocates of a nonaversive approach have not explicitly described what to do when a challenging behavior occurs.

Generally, nonaversive strategies create a reactive vacuum. Ecological strategies, positive programming and focused support strategies do not describe what to do when a behavior occurs; they are proactive, not reactive. Punishment, in contrast, is by definition a reactive strategy and prescribes exactly how to react when the behavior occurs. Given this critical need, in lieu of other suggestions, it is no wonder that some people have held on to their use of punishment.

As shown in Figure 1, the multielement model calls for the explicit inclusion of reactive strategies as a component of a support plan. The outcome requirement that is being addressed by a reactive strategy is a subset of speed and degree of effects. While the proactive strategies address speed and degree of effects over time, reactive strategies address the speed and degree with which individual episodes of behavior can be brought under control, with the least amount of risk of injury to the person, to support staff and to others in the environment. The role of a reactive strategy is not to produce changes in the future, but rather to keep people safe in the here and now.

The model’s liberation of reactive strategies from the need to produce future effects allows more options for the rapid resolution of an episode of behavior than more traditional approaches have provided. This is because the
reactive strategy is planned within the context of a powerful proactive plan that does focus on the future. If we have ecological changes on track, if we are actively engaged in positive programming, and if we have our focused support strategies in place, it is less likely that the reactive strategy will produce a counter therapeutic effect. The following anecdote illustrates this point.

A classroom student was engaging in tantrums, which included disruptive screaming and scratching herself, an average of 40 minutes a day, despite the use of a corner time-out procedure for the previous year and a half. Based on a thorough assessment, a comprehensive support plan was designed. For example, ecological changes included an improved curriculum and a rearranged classroom. Positive programming included teaching her a relaxation response and to communicate using a communication board, with which she could ask to get a drink of water or to go to the bathroom, ask for a break, ask for a magazine, ask for assistance, etc. Focused support included a differential reinforcement schedule of low rates of responding. However, rather than continuing to use the corner time-out procedure as a reactive strategy, at the earliest sign of a tantrum or a known precursor to tantrums, she was handed a magazine. This was selected because support staff knew that when she had physical access to a magazine, she compulsively and immediately stopped whatever she was doing, even tantrums, and removed the staples from the middle of the magazine. Once she completed the removal of the staples, it was quite easy to redirect her back to her educational activities.

From a traditional perspective, such a reactive strategy would be criticized for its potentially counter therapeutic effects. The fear would be that handing her a magazine, with which she engages in a high probability behavior, as a reaction to her challenging behavior, would reinforce and strengthen tantrums. The framework allows the inclusion of such strategies, however, relying on a fully developed proactive plan to overcome the potential counter therapeutic effects of the reactive strategy, that might occur without the context of the proactive strategies.

In the example, what actually happened was that with the initiation of the full multielement plan, tantrums were immediately reduced to an average of less than five minutes a day, a direct result of the effectiveness of the reactive strategy to rapidly establish control over each episode and to prevent its continuation and escalation. Further, her time on-task, engaging in productive instructional activities gradually increased and the daily rate of tantrums gradually decreased. It has now been more than two years since any tantrums have occurred.

We believe that certain reactive strategies, which are in many ways, counterintuitive, such as the one described above, may contribute rapid and safe ways of resolving individual episodes of challenging behavior, if certain guidelines are followed (Willis and LaVigna, in press). This may represent a novel contribution of the proposed multielement model to the field. It also represents a new area of much needed research, to enable us to understand how multielement plans operate and to investigate their possible synergistic capabilities.

**Assessment**

The components of this multielement model, which provides for both proactive and reactive strategies, is dictated by a focus on all six outcome requirements. The design of many of these components requires specific information which only can be gathered through a comprehensive assessment, including the possible influence that neurological, medical or other organic variables may have on the challenging behavior and its meaning to the person, i.e., the function it serves or the message it conveys. The purpose of an assessment process is to determine this meaning.

One strategy for this person centered approach to assessment is to use personal profiling and positive futures planning (Mount & Zwernik, 1988; Patterson, Mount, & Tham, 1988; O’Brien & Lovett, 1992). We have found futures planning to be particularly useful as a way of understanding how the person’s ecology may be affecting behavior and what ecological changes may be helpful in trying to support the person.

Personal profiling and positive futures planning is a two step process designed to provide an understanding of a person’s life and what they have experienced from their point of view and to develop a plan that helps them reach their goals and aspirations for the future. As is the multielement model, this approach is based on five quality of life values: (1) presence and participation in the community; (2) fulfilling valued roles and gaining social respect; (3) maintaining satisfying personal relationships with friends and family; (4) expressing personal preferences and making choices; and (5) gaining skills and competencies. Participating in the

We have found futures planning to be particularly useful as a way of understanding how the person’s ecology may be affecting behavior...
behavioral assessment and functional analysis should be employed.

The fundamental role of behavioral assessment and functional analysis in providing behavioral services represents a hallmark in the field of applied behav-

ior analysis (Kanfer & Saslow, 1969; Schwartz, Goldiamond & Howe, 1975). Assessment methods, information, and materials are considered to have utility if they have been demonstrated to contribute to beneficial outcomes (Hayes, Nelson & Jarrett, 1987). More specifically, the utility of assessment is defined insofar as it bears relevance for developing a support plan (Hayes, Nelson & Jarrett, 1989). Utility research is in its infancy in the area of challenging behavior (Ballmaier, 1992).

As shown in Figure 1, our framework provides for three aspects of assessment as having possible utility. The first of these is the method or process of assessment. Traditionally, the treatment of challenging behavior has relied almost exclusively on direct, naturalistic observation. Increasingly, however, interviewing, records review and analog situations are being utilized (Durand, 1990; Iwata, Dorsey, Slifer, Bauman, & Richman, 1982; O’Neill, Horner, Albin, Storey, & Sprague, 1990; Willis, LaVigna, & Donnellan, 1993). The second aspect of assessment that bears on utility is the information gathered by the assessment process (Ballmaier, 1992). Some content may seem to have obvious utility, for example, knowing the controlling antecedents. Other in-

formation may still be of questionable value to some practitioners, for example, knowing the history of the person and of the specific challenging behavior. Finally, the framework reminds us that assessment materials and devices are subject to exploration for their possible utility, that is, their contribution to the development of effective support plans (Ballmaier, 1992; Durand, 1990; O’Neill, Horner, Albin, Storey, & Sprague, 1990; Willis, LaVigna, & Donnellan, 1993).

Mediation

An inclusive framework for breaking the barriers to integration caused by challenging behavior must also address a variety of mediator issues (Durand & Kishi, 1987; LaVigna, Willis, Shaull, Abedi, and Sweitzer, 1994). Hence their inclusion as illustrated in Figure 1. No support plan, regardless of its comprehensiveness and elegance, will produce the desired outcomes, unless it is fully and consistently implemented. Our model delineates a number of dimensions that relate to this issue. Firstly, three categories of social change agents are identified who may participate on the support team. These include natural mediators such as parent, siblings, regular education teachers, supervisors at work, and others whose relationship to the person is a natural one and has nothing to do with the person’s disability or challenging behavior. Also included are professional staff whose relationship to the person is a function of their disability, such as special education teachers, job coaches, and domestic and community living support staff. Finally, included would be specialized staff whose relationship to the person is a function of the challenging behavior. These might include the behavior consultant, the one-to-one support staff, or others who are involved specifically because of the challenging behavior.

Secondly, the model delineates three aspects of training, as they may relate to the three categories of mediators. These include teaching the general skills that such support people may need to support the person, teaching the specific skills that are necessary to implement the procedures incorporated into the plan and quality assurance systems to assure full compliance with the support plan. Such quality assurance systems include clear and operational definitions of what exactly needs to be done, socially valid monitoring of implementation, feedback based on the results of monitoring to improve and maintain full and consistent implementation, and outcome evaluation (LaVigna, Willis, Shaull, Abedi & Sweitzer, 1994).

We may also need to consider what is reasonable to expect of a person providing support, particularly parents or parent surrogates, regardless of training. Some support strategies may be so involved or some situations so deteriorated that they require professional or even specialized staff. For this reason, we have developed an intensive support approach that allows the provision of specialized services without placing the person in a more restrictive setting or other “challenging behavior unit” (Donnellan, LaVigna, Zambito & Thvedt, 1985).

Conclusion

By design and definition, good research isolates independent and dependent variables and seeks to determine the effect of the former on the latter. The variables not under study are removed or otherwise controlled. In stark contrast, while individual elements may be based on a specific study or group of studies, a person centered support plan has an array of elements, is based on a comprehensive assessment, and is aimed at producing a broad range of outcomes. We suggest that because this broad context is often lacking, research findings may be misinterpreted and misapplied. Additionally, we suspect that the narrow interpretation of research findings has led to practices that many outside the field have perceived as an overuse,
misuse and, in some cases, abuse of the punishment technology.

The model we have proposed is a framework for generating research questions, for discussing research findings, and for incorporating those findings into multi-element, comprehensive, person centered support plans. It also provides a model for guiding behavior analysts in understanding the difference between a person centered support plan and the experimental investigation of isolated variables. If our strength has been in the latter, our weakness may be in the former. By adopting a model such as the one proposed here, we can only enhance the field of applied behavior analysis.

The multielement model is fundamentally derived from the outcomes desired when supporting a person who has the reputation of having challenging behavior. Speed and degree of effect has received most of the focus in the field, but this is only one of the outcomes, for discussing research findings, minimizing negative side effects, social validity, that is, by the effects of treatment. Speed and degree of effect has received most of the focus in the field, but this is only one of the outcomes desired when supporting a person who has the reputation of having challenging behavior.

In this way, the proposed framework provides a values base for addressing challenging behavior. Effectiveness is ultimately measured by clinical/educational validity, that is, by the effects of the support plan on the person’s quality of life, on the person’s increased independence and competence, social and community presence and participation, productivity, personal empowerment and choice, and relationships and support network (O’Brien, & O’Brien, 1991). It is to these valued outcomes that this Multielement model is dedicated.

References


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Behavioral Assessment: An Overview

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Editors’ Note: In Australia recently, several people who attended our training sessions asked “When will you write something about Behavioral Assessment?” Again, we responded with “In the near future.” Indeed, we have been planning for several years to write a How To Do It text on behavioral assessment. Given the interest and requests, we felt that it would be a good time to begin the writing through our newsletter. Periodically, we will provide an in depth discussion of one or more aspects of behavioral assessment. In this issue and the next we provide a two-part general overview.

Introduction

What is behavioral assessment in the context of challenging behavior? This is not an easy question to answer. There are more definitions than you can shake a stick at. Perhaps the best way to define behavioral assessment is by describing its purpose (although there is little agreement here either). Generally speaking, the purpose of a behavioral assessment is to understand the person and by so doing answer questions such as: Why is the person engaging in the behavior? How does the person use the behavior to solve everyday problems?

It might also be helpful to understand what behavioral assessment is by understanding what it is NOT. It is not simply observing behavior and collecting baselines; it is not simply collecting ABC data; it is not simply defining the challenging behavior, identifying antecedents, identifying consequences and attributing the behavior to positive or negative reinforcement.

Challenging behavior can be very complex and can occur for a wide variety of reasons. There is a growing awareness of how behavior might be used by people to communicate (Donnellan, Mirenda, Mesaros, and Fassbender, 1984; Carr and Durand, 1985; Carr, Levin, McConnachie, Carlson, Kemp, and Smith, 1994; Reichele and Wacker, 1993). For example, some people with severe learning difficulties have learned that screaming “bloody murder” or other challenging behavior can communicate important messages; not unlike a person using sign language.

In addition to communication, it is well established that some people may use challenging behavior such as self injury and aggression to escape unpleasant activities such as tasks and demands (Carr and Newsom, 1980; Carr Newsom and Binkoff, 1976, 1980). People may also engage in challenging behaviors because it simply feels good, or generates interesting sensory stimulation (Baumeister and Forehand, 1973; Favell, McGimsey, and Schell, 1982; Rincover and Devaney, 1982); because the behavior gets them what they want (Durand and Crimmins, 1988); and because the behavior gains the attention and social contact of others (Carr and McDowell, 1980; Martin and Foxx, 1973). Indeed, people with severe behavioral challenges may use a single behavior such as self injury to satisfy all of the above functions and many not mentioned.

In order to answer the question “Why does Johnny hurt himself?” — in order to

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The Methods of Behavioral Assessment

Answering these questions and understanding the person requires, in our opinion, a comprehensive two part process. The first of these is a thorough process of information gathering. The second is the very disciplined process of summarizing, synthesizing and analyzing that information in a formal Behavioral Assessment Report. This report then forms the basis for a Recommended Support Plan. Because of the time involved, many people stop the process of assessment at the information gathering phase. They believe that information gathering is sufficient to understand the meaning of the behavior and the role it serves for the person. However, we have found that a certain level of understanding is only achieved through the writing of a formal assessment report following a particular format. The process of assessment is like putting a puzzle together. Information gathering is that part of the process that assures that we have all the pieces of the puzzle. However, even with all the pieces of a thousand piece puzzle in front of us, we wouldn’t be able to see the picture without putting the pieces together in a particular way. The writing of a formal assessment report, following a particular format, is that part of the process that puts the pieces together so that you can see the picture. The assessment process is incomplete without the summary, synthesis and analysis that occurs in the writing phase. Appendix A of our Behavior Assessment Guide (Willis, LaVigna & Donnellan, 1993) provides a detailed checklist and description for writing each section of a formal assessment report.

Behavior assessment involves gathering information from a wide array of resources, including interviews with and questionnaires completed by the person and parents, friends, teachers, etc.; reviews of records and files that include past and current medical, educational, psychological and other evaluations, that describe important historical and current events, and that document previous attempts to solve the problems and the results of those attempts; role playing...
selected events with the person; test situations to see the person’s reaction, etc. Very importantly, a behavioral assessment involves direct observation of the person in a variety of situations.

For gathering information, we use the Behavior Assessment Guide (Willis et al., 1993). The Behavior Assessment Guide is an information gathering and records abstraction tool. It is a structured interview guide, an instrument where information derived from records can be summarized, and an instrument where the results of direct observation can be organized. We feel that by organizing information from a variety of sources into one structured tool, we increase the likelihood that all of the relevant information is gathered, which, in turn, increases the likelihood that the functions served by behavior can be better identified when this information is summarized, synthesized and analyzed in a written assessment report.

The 2-phase (information gathering and report writing) IABA assessment process (Willis et al., 1993) that we are describing here has been in almost continuous development since 1982 (LaVigna and Willis), as part of our multielement model for breaking the barriers to social and community integration for people who have challenging behavior (LaVigna & Willis, 1995). From the beginning, we have attempted to make this assessment process as comprehensive as possible, to give us the best and most complete understanding we can have about the meaning of the behavior for the person, i.e., the function it serves. Our earliest (LaVigna and Willis, 1982) assessment scheme and the first edition of our Behavior Assessment Guide (Willis and LaVigna, 1984) adopted a strategy similar to that described by Kanfer and Saslow (1969) and other pioneers in the field (e.g., Donnellan et al., 1984; Durand, 1990; and Touchette, MacDonald, & Langer, 1985). In contrast, the approach to assessment we are describing here is designed to be comprehensive. Its practicality may not be in the time required to carry out the assessment or in the training necessary to do it right. Rather, its usefulness is in the critical mass of information and the person centered understanding of behavior it provides, which may be necessary if support plans based on the less comprehensive and less formal methods of assessment have failed. (We will extend our discussion on the cost effective design and arrangement of behavioral services in the summary and conclusion section of this article which will appear in the next issue of Positive Practices.)

1. Analysis of the Problem Situation.
2. Analysis of the Historical Setting Events.
3. Analysis of the Antecedents.

...if any of the following three criteria are satisfied, then a comprehensive approach to assessment, such as we are describing here, should be considered ...

4. Analysis of Consequence Events.
5. Analysis of Organismic Variables.
7. Skills Analysis:
   a. Motor abilities.
   b. Self-help skills.
   c. Independent living skills.
   d. Social skills.
   e. Cognitive abilities.
   f. Expressive communication skills.
   g. Receptive communication skills.
   h. Vocational skills. Etc.
8. Analysis of Mediator Resources and Abilities.

Those of you who are familiar with our current Behavior Assessment Guide (Willis et al., 1993), will recognize that we have continued to emphasize a comprehensive approach to assessment, as exemplified by Kanfer and Saslow (1969) and other pioneers in the field (e.g., Schwartz, Goldiamond & Howe, 1975). In its fullest application, we believe this assessment process requires training. We also recognize, that a comprehensive assessment is time consuming. This raises an important question. Does everybody on a caseload identified as needing behavioral support services require this process? We don’t think so. In fact, we believe that it would be wasteful of resources to use this method of assessment for everybody who has been identified as requiring behavioral support. We would suggest, however, that if any of the following three criteria are satisfied, then a comprehensive approach to assessment, such as we are describing here, should be considered and may be justified:

1. A comprehensive behavioral assessment is recommended when the person’s challenging behavior persists despite consistently implemented support plans that have been based on less comprehensive and less formal methods of assessment.
2. A comprehensive behavioral assessment is recommended when the person’s behavior places the person or others at risk. This is not just at risk of harm or injury but also risk of further exclusion and devaluation.
3. A comprehensive behavioral assessment is recommended when you are considering an aversive, intrusive or restrictive procedure.
An Overview Of Behavioral Assessment

As described above, behavioral assessment involves gathering information in a wide variety of domains. Table 1 summarizes the major areas of focus in a comprehensive behavioral assessment (Willis et al., 1993). Each of these areas are discussed briefly below in our effort to show how this information may be relevant to understanding why a person engages in a particular behavior and how that information may be useful in designing an individualized support plan.

A. Referral Information. The process begins with the referral. It may be initiated by an agency such as the Regional Centers of California, or other funding agency. It may be a parent, a teacher, a caseworker, or one of your staff. It is with the referral that the assessment begins. The initial problems and related issues are described. Based on the referral contacts, concerns are explored that might influence the assessment process or the support plan. The referring agency is asked to describe the level of anticipated cooperation of the people who will participate as informants in the assessment and as mediators of the support plan. It is also during this initial referral that priorities may be established. For example, we would consider a person as a “priority” for a support plan if his or her behavior represented a threat to others, themselves, or to their services.

B. Description of the Person. Behavioral assessments traditionally have paid very little attention to “The Person.” The focus has been almost exclusively on “The Target Behavior.” We have learned that by knowing more about the person, understanding the person’s strengths and weaknesses, we can design better support plans.

1. Physical Characteristics. A person’s physical appearance may contribute to behavioral challenges in several ways. The person may have a physical disability that results in ridicule from others. The person may be of intimidating dimensions and consequently those around him may shy away out of fear. The person may have a dirty, grungy appearance or smell badly which may result in social isolation. The person may have a problem walking which influences her ability to move quickly in the community. The person may have a physical disability that simply prevents participation in certain activities. The way a person appears, carries himself or behaves during the assessment may suggest the presence of a possible neurological problem, the side effects of a medication, and may suggest that there are simply some things that the person cannot be expected to do.

2. Cognitive Abilities. We know that many of you who are reading this article conduct psychological and developmental assessments for the people you serve. You also write the results. Does it bother you that frequently “no one reads your reports.” We say this somewhat jokingly, but our experiences reading support plans suggests that it may be more true than not. At least the information contained in your evaluations did not get into the person’s support plan. On the other hand, perhaps they just didn’t understand what they were reading. That is a little frightening.

It is important to gain an understanding of how the person uses information, how the person learns, and what the person has learned. Some of the questions we attempt to answer include the following: What does formal testing reveal regarding the person’s learning abilities? How does the person learn best? What is the person’s preferred mode of learning? Visual? Auditory? Motor? What is the person’s ability to handle concrete and abstract concepts? What are the person’s skills in the area of reading, writing, calculation, time determination, matching, imitation, picture recognition, etc. Does the person have memory difficulties, and how does the person best remember what has been presented? What are the person’s abilities with regard to impulse control? The answers to these and other related questions may bear strongly on understanding the meaning of the behavior for the person and on developing an effective plan of support.

3. Communication Abilities. As we noted above, people frequently use their challenging behaviors to communicate everyday messages. This is particularly the case for people with severe learning difficulties. If
we are to develop a plan to meet the person’s needs, we must first get an understanding of the person’s strengths and weakness in this area. So, as part of a comprehensive behavioral assessment we ask “How does the person ordinarily communicate his needs (e.g., sign language, pictures, words, augmentative systems, sounds, visual gaze, etc.)?” We attempt to determine the person’s communicative fluency and understandability. We attempt to determine how the person indicates she wants certain objects, indicates she wants someone to do something, and indicates she wants someone to stop or cease an activity or action. We also attempt to determine the degree to which the person understands the communicative attempts of others, including conversation, requests, questions, etc. Here is one of many questions we might ask: “People communicate their everyday needs in many ways. Do you ever have the feeling that your daughter uses hitting to send you a message? What is that message?”

4. Self-Care, Domestic, Community, Leisure, Social Skills. People with severe learning problems frequently have a wide range of skill deficits. Consequently, they must rely on those around them to meet even the most basic of needs. For example, a young man who experiences hunger must wait until one of the scheduled meals to eat. He has not learned to communicate he is hungry and has not learned to get a snack himself. He must rely on the good will of those around him to satisfy this need. Frequently, he becomes so frustrated that he assaults staff around the mealtime.

Another young woman has never learned how to play with others or how to initiate contact other than through hitting. Consequently, she has no friends with whom to do things and must be “entertained” by paid employees.

As part of a comprehensive assessment, we attempt understand how the person’s life with her family may be influencing or have influenced the person’s behavior. Some of the areas we would explore include the following: Who has responsibility for child care and behavior management? Is this a single-parent family? Is there agreement regarding the management of the person’s behavior? What is the parents’ view of their role? What conflicts exist in the home? How many other children are present in the home? Do they have disabilities? Challenging behavior? What does the family do together? Does the family have the physical, emotional and financial resources to carry out a support plan?

These questions, of course, assume the focus person is a child. Comparable information would be needed to understand the family history and background when the focus person is an adult.

2. Living Arrangement Other Than The Family Home. A person’s behavior can be dramatically influenced by where the person lives and the conditions under which they live. Take, for example, your experiences in college living with roommates. Were there roommates that you simply did not mesh with? Was your behavior influenced by their presence or...
Does the person have any interest in the activities being performed? Does the person have any control over what they do and can they make choices?

spaces with little or no privacy? Do you remember the impact of people (usually sergeants) yelling, demanding and telling? Do you remember the impact of having little or no control over your lives? Surely you can remember how events such as these influenced your behavior.

As part of a behavioral assessment it is important to investigate how aspects of the person’s living arrangement (e.g., group home, supported living, development center) might contribute to the person’s behavior. Could the person’s behavior be a partial reflection of such things as congestion, crowding, lack of privacy, lack of food, filth, lack of things to do, and down time? Could the person’s behavior be a reflection of the people with whom he lives? Perhaps the person assaults because that is what everyone else is doing, (i.e., it is a result of behavioral contagion); perhaps the person hurts himself because there is nothing better to do; perhaps the person leaves the home because there are not enough staff to provide the level of support needed, and the staff who are present are untrained.

3. **Program Placement.** Most of the people we support receive some form of formal daytime service. Some are being served by the local schools. Others receive services through day-treatment programs. Others go to workshops and many have jobs. A person’s challenging behavior can be a direct reflection of daytime services that should meet important needs. For instance, the work setting might be too congested or too noisy. The type of work activity might be boring or too difficult for the person. Or the person may not have anything meaningful to do. Some questions that we might attempt to answer here include the following: Are there aspects of the physical location that might increase the likelihood of challenging behavior? Does the arrangement of the learning environment (e.g., arrangement of desks, school without walls) influence the person’s behavior? Are the activities meaningful, or are they just “make work?” Does the person have any interest in the activities being performed? Does the person have any control over what they do and can they make choices? What type of teaching methods are being used and are they appropriate for this person? Are the teachers and staff trained and knowledgeable about how to serve people with particular disabilities and learning difficulties?

4. **Health and Medical Issues.** I think all of us can agree that our medical state has an impact on how we behave from day to day. When we are ill, we frequently make adjustments in our lives. We make a doctor’s appointment; we call our employer and ask if we can take a day off; we might stay home to reduce the demands on ourselves. Unfortunately, when we are asked to carry out an assessment for a person in crisis, we frequently find that the crisis is a direct result of an unidentified medical problem. All too often, “behavior management programs” have been developed to “treat” people whose behavior is a reflection of medical issues. For example, a woman with severe learning difficulties who lived in a large state hospital had been “treated” for most of her life for rumination and regurgitation. When she would eat, she would regurgitate the food repeatedly, chew it and re-swallow it. As part of a behavioral assessment it was suggested that she receive a thorough medical examination, to include an upper GI. The examination revealed that the opening to the woman’s stomach was so small that only the smallest pieces of food could enter her stomach. A medical procedure that involved dilation of the opening to the stomach ended the problem; this after years of “behavior management programs.”

Similarly, a man with severe learning difficulties was referred because of cyclical self injury and what was termed “operant vomiting.” He, like the woman above, had been subjected to a wide range of “behavior management programs.” Because of the cyclic nature of the behavior, and because of the accompanying vomiting, a complete medical evaluation was requested. The physician identified that the young man had very severe ulcers and gall stones. Why do you think he was hurting himself? Why do you think he would vomit?

As part of a behavioral assessment it is important to ascertain whether the person has any medical issues that might
impact the behaviors. It means reviewing existing medical records in an effort to connect possible physical/medical/neurological findings and events with changes in the person’s behavior. It involves asking people and reviewing records to determine whether the person has now or has had in the past, neurological problems, heart or circulatory system problems, respiratory problems, digestive problems, genital/urinary problems, visual/hearing problems, or endocrine problems. It means attempting to determine whether the person has a history of allergies or seizures.

As part of the review in this area, it is also important to review the person’s history of medication for psychiatric and behavioral challenges. Some of the questions that should be addressed include the following: For each medication, what is the name, prescribed dosage, and schedule of delivery? When was the medication initiated, and is it doing what it is expected to do? (It is not unusual for people to spend years on medication with little or no benefit.) In addition, you should have a resource (e.g., Physician’s Desk Reference [1996]) that helps you determine whether the medication is within therapeutic range and describes the major side effects you might encounter. You should also have a ready resource that describes the Federal Drug Administration maximum dosage. For example, many people who manifest physical assault are given Haldol. Resources suggest that daily dosages up to 100 mg may be necessary under some circumstances. It is infrequent for a person to receive more than 100 mg per day and there is limited understanding of the therapeutic value above this level. Finally, when a person is receiving several medications you should explore possible interactions and negative side effects associated with certain combinations of medications (See the Physician’s Desk Reference’s Drug Interaction and Side Effects Index). For example, Mellaril can potentiate the effects of medications such as Phenobarbital, Inderal, etc. A good idea is to have on hand a respected psychiatrist who is willing to answer questions regarding proper medications and combinations.

5. Service History. It should not be surprising to you that people with disabilities and challenging behavior may spend a lifetime being subjected to a variety of support strategies. It is not unusual for support strategies to be used for a few months, be abandoned for some undescribed reason, and to be re-initiated months or years later. It is also not unusual to find in a person’s history, procedures that have escalated in severity and level of restrictiveness as the months and years have passed. For example, we conducted an assessment a number of years ago for a woman who engaged in physical assault and self injury. A review of records showed the following chronology of support strategies:

- 8/3/81 to 8/13/81 - Restraint on mat and contingent release.
- 8/14/81 to 9/3/81 - Arm splints and protective helmet.
- 9/4/81 to 9/17/81 - Mittens and protective helmet.
- 9/17/81 - Total protective helmet. Quiet training overcorrection for agitation.
- 6/82 to 9/83 - Helmet, mitts, posey belt, and restraint jacket.
- 8/2/83 - Add basket hold in chair for each incident.
- 4/8/85 - Aversive Faradic Stimulation (Shock) for head banging, nose picking, and face scratching.
- 4/10/85 - Add Shock for touching her head.
- 4/18/85 - Add Shock for finger picking.
- 4/19/85 - Add Shock for scratching staff.

This is an extreme example, but perhaps not that unusual. The immediate questions such scenarios raise include: Why was it necessary to escalate the “treatment” severity? Why was it necessary to resort to such extreme aversive events? What was the impact of “treatment”?

To answer these and other questions, the behavioral assessment attempts to answer a variety of questions regarding the person’s service history. Some of these questions include the following:

- Was the support plan based on a comprehensive behavioral assessment?
- Did the assessment identify potential reasons for the behaviors (i.e., functions)?
- Was the strategy based on the identified functions?
- If behavioral strategies were used, did they adhere to the rules of Good Behavioral Technology (e.g., contingency, immediacy, salience, etc.)?
- Were the strategies implemented consistently and if so, were they implemented in a way that they could be effective?
- Did the support plan take into account the person’s history?
consideration what is known about the person’s disabilities, strengths and weaknesses? For example, we currently are working with a young man who at the age of 17 had a motorcycle accident which resulted in major brain injury. Years after the accident, his memory is severely impaired. He has difficulty remembering the names of people who have worked with him for years. It makes no sense to use consequence based strategies with this young man, since he would have no memory for the reinforcement. So, his support plan is based on the antecedent arrangement of his environment such that desirable behaviors are more likely and undesirable behaviors less likely.

D. Mediator Analysis. Mediators are those individuals who we would expect to carry out a support plan (e.g., parents, teachers, staff). Traditionally, when a person with challenging behavior was referred for services, a support plan was designed to be carried by those individuals currently involved with the person. Little attention was given to whether they wanted to participate or not. Perhaps the belief we had was that all people want to and can carry out our recommendations. Of course, with a good dose of common sense and experience it is apparent that this is not true. Not all support plans can be carried out under all conditions.

In order for a support plan to be successful, the people who will be responsible for carrying out the plan must want to, they must be motivated to participate, they must have the skills, they must have the physical and emotional abilities to carry out the plan, and there must be sufficient people resources (i.e., staff to client ratio) to implement the plan (Carr et al., 1994).

Thus, the Mediator Analysis attempts to identify the conditions necessary to implement the person’s individual support plan. In an effort to do this, we attempt to answer several important questions. For example:

1. Do the mediators wish to participate in implementing the support plan? Are they likely to cooperate with recommendations?
2. Do the mediators have the training and knowledge to implement the recommendations; and if not, how much and what type of training will they need?
3. Do the mediators have the physical and staffing resources to carry out the support plan recommendations?
4. Are there barriers (e.g., social, emotional, financial) that might preclude the mediator from carrying out recommendations?
5. What additional resources and services are necessary for the plan to be implemented successfully?

E. Motivational Analysis. If a person’s support plan calls for the use of reinforcement, it should go without saying that effective reinforcers need to be identified. While the research literature is replete with references as to the importance of identifying important/powerful reinforcers (e.g., Koegel and Mentis, 1985; Goetz, Schuler, and Sailor, 1983), it has been our observation that this is perhaps one area in which very little focus is given when designing specific procedures to be included as part of a support plan. The rewards used are “what is available at the time;” or the rewards are the same for everyone in the setting. Very little effort is given toward individualizing or identifying truly meaningful incentives. What gives us the idea that a person will be willing to change his behavior for praise every 15 minutes, or a treat every two hours, or a nickel at the end of the day. The person may command the entire environment with his behavior - change for a nickel? Doesn’t make much common sense.

If reinforcement is to be used as part of a support plan, then we must spend the time to identify powerful incentives, incentives that the person would do nearly anything to acquire. Not only must we identify what the person has an interest in, but also how much it takes to motivate the person to begin participating in the program. For example, how many of you reading this would be willing to wash our cars for $1? I bet none. How about $5? Would you wash our cars for $1000? Sure you would. This is the point. While you may like money, you are not willing to begin participating until the quality of the reward achieves a certain level; the “threshold of activation.”

There is an entire technology that surrounds the identification of meaningful reinforcement. Ask those who know the person to describe her likes and dislikes; observe the person to see what the person does often; ask the person what he is willing to work for; have the person write what he would like to earn on 3 by 5 inch cards and then order the cards from left to right with the most highly preferred items being placed to the right; or give the person the opportunity to choose from an array of events that people describe as preferred. We frequently give several people who know the person one of the reinforcement inventories out of the Behavior Assessment Guide (Willis et al., 1993) to complete. This is a questionnaire that rates well over 100 items on a scale from “Very Much Preferred” to “Not At All Preferred.”
Of course, many challenging behaviors occur within the context of a low general level of reinforcement (Cautela, 1984). Our assessment should also be aimed at determining the person’s general level of reinforcement. If it is low, a support plan might very well include the strategy of increasing the person’s general level of noncontingent reinforcement. For those situations when, in addition, plans call for contingent reinforcement, caution should be exercised to assure the those events that are used contingently do not represent events that the rest of us get to enjoy on a noncontingent basis and, certainly, do not include those things that a person has a right to, regardless of their ability to meet some behavioral criterion established by another person. Contingent reinforcers, if used at all, should represent extra incentives that go beyond the noncontingent quality of life we would want everybody to enjoy.

**F. Ecological Analysis.** Early approaches to behavioral assessment focused almost exclusively on contemporaneous (i.e., current) behavior and conditions. In other words, we focused on the “here and now.” It is only relatively recently that due attention is being given to broader contextual events that might influence a person’s behavior (Rhodes, 1967; Barker, 1968; Rogers-Warren and Warren, 1977; Scott, 1980; and LaVigna & Donnellan, 1986). We have learned what “common sense” has known for a hundred years; that is, current behavior can be influenced by crowding, social roles, expectations, parental stress, the behavior of others, the types of activities available to the person, etc.

Contingent reinforcers, if used at all, should represent extra incentives that go beyond the noncontingent quality of life we would want everybody to enjoy.

Given this understanding, the behavioral assessment has as a goal the identification of those ecological events that might be negatively influencing the person’s behavior. But it should be rather clear that one does not just set out to do an “Ecological Analysis.” Rather, ecological events are identified from the analyses we do in all of the areas we describe above. Table 2 summarizes some of the ecological features that might be explored as part of a comprehensive assessment.

Here is an example of an ecological tragedy that goes on every day. All of you who are reading this article know, or are aware of, a person who goes to work each day to support an individual with learning difficulties and/or challenging behavior. You also know that this person does not like the individual he/she is supporting. And you may have heard this person describing the individual in very disparaging ways (e.g., “retard,” “vegetable”). How can this person even begin to provide the support that is needed by the individual with learning difficulties? Could the person’s challenging behaviors be a direct reflection of being in an instructional context with people who do not like him? Common sense suggests “yes!” How would you feel, and how would you behave if you had to go to work everyday with people who don’t like you and let you know it?

Editors' Note: This article, “Behavioral Assessment: An Overview”, will be concluded and references cited in the next issue (Vol. 1, No. 3, April, 1996) of Positive Practices.

(End of Part 1)
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In Part 1, we introduced the concept that a Comprehensive Behavioral Assessment is more than simply identifying a target behavior, its antecedents and consequences. It is more than just a Functional Analysis. We said "the purpose of a behavioral assessment is to understand the person and by so doing answer questions such as: Why is the person engaging in the behavior? How does the person use the behavior to solve everyday problems?" We also made the point that in order to understand the person, the behavioral assessment involves gathering information in a wide variety of domains. Table 1 summarizes the major areas of focus in a Comprehensive Behavioral Assessment (Willis et al., 1993).

In Part 1, we addressed Sections A-F as shown in Table 1, concluding with Ecological Analysis. Here in Part 2, we discuss the Functional Analysis of Behavior, the hallmark of what we do as behavior analysts. This is an extremely important part of a Comprehensive Behavioral Assessment. Unfortunately, some people have the view that the Functional Analysis and Behavioral Assessment are synonymous. They are not!!! The Functional Analysis should be part of the larger and more comprehensive Behavioral Assessment. With that understanding, let's discuss what is involved in a Functional Analysis of Behavior.

G. **Functional Analysis of Behavior.**

The purpose of a Functional Analysis 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).
The Functional Analysis also has as its purpose the clear specification of the identified challenging behavior (i.e., Operational Definition). At a minimum, a functional analysis specifically includes a Description of the Problem, a History of the Problem, an Antecedent Analysis, a Consequence Analysis, and an Analysis of Meaning.

1. **Description of Problems.** In this part of the functional analysis, the primary problems precipitating the referral should be determined. Whether they fall into the class of behavioral excesses or behavioral deficits should also be determined. These determinations would not necessarily be the formulations of the problems as provided by the referral source but rather should be the most useful formulations developed based on an analysis of the information that has been gathered. While many people may think that describing the problem should be the easiest part of the functional analysis, we have often found it to be among the most difficult. Good descriptions include descriptions of the topography, the cycle the course and the strength of the behavior.

a. **Topography.** The topography of a behavior is a description of its observable and measurable components; it is a description of the physical characteristics that signal to the observer that the behavior has occurred. In determining the physical characteristics of a behavior, we ask “When the person engages in the behavior, What does it look like? What does it sound like? What does it smell like? What does it taste like? For example, the topography of “Aggression” is frequently described as including hitting, biting, kicking, scratching and/or pulling the hair of another person, attempts to do so, and/or verbal and/or gestural threats to do so. Each one of the individual actions needs to have a description of its topography. It is not sufficient to say “Aggression involves hitting and biting.” Rather, the topography of aggression might be more clearly expressed in the following way:” “Aggression involves several distinct actions, including hitting (i.e., any contact with an open hand or closed fist to the body of another with sufficient force that the contact can be heard or the person’s body is moved or jarred as a result of the contact); biting (i.e., any contact of the person’s teeth to the skin or clothing of another). It should be clear from the above description that simply touching another person with a hand, or knuckles is not an example of aggression.

This is not to say that this is how the topography of “Aggression” should be defined, but rather that this is how it might be defined, given the information that is gathered as part of the assessment process. (Note: The tendency is to have generic definitions that apply to everyone.) For example, in any given case, it may not be appropriate to include verbal and/or gestural threats within the definition of “Aggression.” The point is that if we don’t specify what we intend to include then, for example, some people will score attempts as “Aggression” and some won’t; some people will score threats as “Aggression” and some won’t; and so on. Let’s say you wish to include “verbal threats” as part of the definition of aggression. Like “hitting,” the topography of “verbal threats” needs to be specified. So we might add to our above description, “Aggression also includes verbal threats (i.e., Verbalizations the content of which indicate the intent to strike or injure another person, e.g., “I’m going to hit you.” “I’m going to kill you.”)."

Here is another example, the topography for “Noncompliance” might be described as the failure to initiate a requested activity, with the requirement being that the request be reasonable, asked within an appropriate context, be understood by the person, and be within their capabilities.

b. **Cycle.** The “cycle of the behavior” breaks the behavior into countable units. Here we ask “At what point will we say the behavior has started and at what point will we say the behavior has stopped?” In other words, we specify the “onset criteria” and the “offset
criteria.” For example, the
cycle for “Aggression” may
be stated as follows: “An
episode of Aggression is
considered to have begun
upon observation of any of
the above topographies. An
episode is considered over
after five minutes have gone
by without any of the to-
pographies being ob-
served.” The cycle here
includes both the onset and
offset criteria.

The cycle for “Noncom-
pliance” may be stated as
follows: “An incident of
Noncompliance is consid-
ered to have occurred if the
requested activity has not
been initiated within five
minutes of the first request.”
In the case of “Noncom-
pliance”, the cycle does not
require an offset criteria.
Rather, the cycle for non-
compliance can be clearly
defined with a well stated
“onset” criterion. Again, it
is important to note that the
cycle definition would fol-
low the information gather-
ing phase. For example,
the onset criterion for “Non-
compliance” would vary de-
pending on the person’s
cognitive abilities, motor
skills, etc.

c. Course. The course of the
behavior is a description of
the behavior as an episode
occurs over time, i.e., it is a
time lapsed, “frame by
frame” description of an
episode. The course de-
scription includes a num-
ber of elements: 1) the pre-
cursors to the behavior, i.e.,
those things the person typi-
cally does prior to the onset
of the behavior; 2) the to-
pographies of the behavior
as they unfold or may esca-
late as the episode contin-
ues; 3) the other things the
person may do during an
episode, in addition to the
topographies that have been
included in the definition;
4) a description of the
person’s emotional expres-
sions during an episode of
behavior; and 5) a descrip-
tion of the post-cursors to
the behavior, i.e., a descrip-
tion of what the person typi-
cally does after an episode
is over.

Typically, a challenging
behavior has different
courses, some severe and
some mild. In our descrip-
tion of the behavior, we may
want to describe a typical
course, a severe course, and
a mild course. In our ante-
cedent analysis (see below),
we would attempt to iden-
tify those reactions by oth-
ers that tend to make a se-
vere course more likely to
occur and those that tend to
make a mild course more
likely to occur.

d. Strength. There are many
measures of the strength of
a behavior. The most typi-
cal measure of strength is
the rate of the behavior, i.e.,
the frequency of behavior
during a specified period of
time (e.g., four times per
week, six times per month,
fifty times an hour). A func-
tional analysis should in-
clude a statement reporting
the rate of the behavior, in-
cluding its range and vari-
ability.

Duration (i.e., the length
of time a behavior is per-
formed) is another measure
of the strength of behavior.
In the case of behaviors that
continue for a period of time
(e.g., screaming, tantrums,
off task) or have been de-
finited in terms of episodes
(e.g., “A tantrum starts at
the appearance of the first
scream and ends when
screaming has been absent
for five minutes.”) it is im-
portant that the functional
analysis describe the aver-
age, shortest, and longest
durations.

There are other measures
of strength of behavior.
Rather than measuring the
length of time a behavior is
performed, “Latency” is a
measure of the amount of
time it takes a person to
“start” or “begin” a behav-
ior. Kazdin (1994) defines
latency as “The amount of
time that elapses between a
cue and the response.”
Some examples of latency
are the amount of time re-
quired to start work after
being directed to start; the
length of time to start eat-
ing dinner after arriving at
the table; the amount of time
it takes a child to get into
bed after the time for bed
has been announced.

Other measures of
strength may be determined
by their obvious importance
to the behavior of interest.
For example, in weight con-

roll programs important
measures of strength might
include the person’s weight
in pounds, the number of
calories consumed each
day, the number of fat grams
consumed each day, the
number of minutes of exerci-
ses each day. In energy
conservation programs, im-
portant measures of strength
might include daily read-
ings of the electric meter or
gas meter. In programs to
help youngsters with dia-
""
rate of the behavior may not be the most important measure of its strength. For example, a 5-year-old has tantrums. His mother describes them as “very serious.” She described that they occur about once a week. With only this information we might be inclined to ask “What’s the problem? My child at five had tantrums every day.” The tantrums are serious to this parent not because they occur once a week, but because when they occur they go on for 3 to 4 hours. In other words, the “seriousness” is measured by the perceived severity of the behavior. Consequently, in some cases, the severity of the behavior also needs to be described.

Severity may be described as a measure of the “impact” of the behavior; the “damage” accrued by the behavior; or the perceived seriousness of the behavior. For example, if the target behavior is someone’s “Screaming” behavior and it is occurring about once a day, while last year it was occurring 18 times a day, this is not necessarily an indication that the problem is getting better. The once a day may be from 6:00 AM continuously to 9:00 PM. In this case, in addition to rate, we may also want to describe the duration of the behavior. Duration is one way to describe severity.

Different measures of severity may be used, but this would depend on the target behavior and the results of the information gathering process. For a referral problem such as “Property Destruction,” in addition to the rate of the behavior, its severity may be described in terms of the monthly costs of repair and replacement.

The history of behavior has played a very small part in behavioral assessment until recently. In episodes of self injury and physical aggression, severity might be measured on a five point scale with “5” indicating the need for medical attention, “4” indicating the need for first aide, “3” indicating redness and bruising that lasted more than four hours after the event, and so on.

It would be nice if reliable data were available for each assessment we conduct. Unfortunately, it frequently is not. If formal data collection has not been carried out or if the cycle used to define the behavior is different than the one that has been used by others, estimates may need to be made based on whatever documentation that exists. These estimates will need to be based on careful interviewing of parents, staff and/or others who have observed the behavior. Of course, these estimates would need to be refined as reliable data collection is carried out.

As can be seen from the above, a good description of a behavior can be quite involved. The information can be difficult to get and can require a lot of information gathering. A good description of the identified challenging behavior is necessary, however, in order to focus the other steps of the functional analysis. A good description of the identified challenging behavior is necessary to assure reliable data collection for purposes of evaluating the effectiveness of support plans, to assure consistent implementation of support plans, and to increase the likelihood that the person will learn the relevant skills. Knowing that the complexity of this part of the functional analysis is often underestimated, the first three issues of this newsletter have included sample definitions from some of our assessment reports. We will continue to include further illustrative examples in future issues.

2. History of Problems. The history of behavior has played a very small part in behavioral assessment until recently. Indeed, the traditional focus of behavioral assessment has been on current behavior and current maintaining variables. It has been argued by some that it is not necessary to know a person’s history in order to change behavior. While this may be true, knowing a person’s history and the history of the problem may help determine whether a behavioral approach is the best course, or what type of approach might be the first choice, or how long support might be needed.

The lack of focus on history is surprising given early descriptions of its importance. Kanfer and Saslow (1969), for example, argued the importance of history when they wrote “...knowledge of the patient’s history, of the limits of his capacities, and
of the norms of his membership and reference groups is essential for effective therapeutic planning.” (p. 427) They wrote further “A behavioral analysis excludes no data relating to a patient’s past or present experiences as irrelevant. However, the relative merit of any information (e.g., growing up in a broken home or having had homosexual experiences) lies in its relation to the independent variables which can be identified as controlling the current behavior which requires modification. The observation that a patient has hallucinated on occasions may be important only if it has bearing on his present problem.” (p. 438)

The importance of history in the development of a support plan cannot be overemphasized. For example, a woman with a severe disability was referred because he refused to go to school. Every effort to get him to school had been unsuccessful. Exploration of the history of the problem with his parents suggested that he was not simply refusing to go to school, he was avoiding a threatening world made up of “large, dangerous, dogs.” (He had an unpleasant experience with a 200 lb. St. Bernard one morning before school). Given this information, a reinforcement program for going to school was not recommended. Rather, a counterconditioning plan was recommended and carried out successfully. The history of the problem suggested a starting point for the support plan.

History is not unimportant. Consequently, when conducting a functional analysis it is important to gather information regarding the history of the challenging behavior. Some of the questions we need to ask include the following: When did the behavior first appear? How long has the behavior been evident? Have there been recent increases or decreases in the behavior? Have there been any environmental, physical, or emotional changes that may have influenced the behavior? Knowledge regarding the history of the problem may be helpful in determining the person(s), places, times, activities, events, interactional styles, etc. that make the behavior more likely to occur and/or to escalate and those that make the behavior less likely to occur and/or to escalate.

While an antecedent analysis is well recognized as a fundamental component of a functional analysis, it is difficult to do well. Without proper training, we ask the wrong questions or we simply don’t know what questions to ask. We frequently ask parents “What sets off the behavior?” and are surprised when they say “We don’t know!” or “Everything!” Without proper training, records and interviews often do not easily yield useful information. The following discussion may be helpful for future antecedent analyses.

Nothing Is Perfect. People mistakenly think that for an event to have an antecedent relationship with a behavior, that the relationship has to be a perfect one. That is, that the presence of another instance, a 7-year-boy was referred because he refused to go to school. Every effort to get him to school had been unsuccessful. Exploration of the history of the problem with his parents suggested that he was not simply refusing to go to school, he was avoiding a threatening world made up of “large, dangerous, dogs.” (He had an unpleasant experience with a 200 lb. St. Bernard one morning before school). Given this information, a reinforcement program for going to school was not recommended. Rather, a counterconditioning plan was recommended and carried out successfully. The history of the problem suggested a starting point for the support plan.

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Nothing Is Perfect. People mistakenly think that for an event to have an antecedent relationship with a behavior, that the relationship has to be a perfect one. That is, that the presence of
an antecedent indicates that the behavior is either certain to occur or, alternatively, certain not to occur. However, an event is considered to have an antecedent relationship with a behavior when that antecedent changes the probability of that behavior’s occurrence, making it either more likely to occur or, alternatively, less likely to occur. Not seeing perfect relationships, that is, always seeing exceptions, we often overlook those events that do, sometimes very dramatically, effect the probability of a behavior’s occurrence.

Antecedents May Be Complex. Secondly, often there are complexes of antecedents, rather than isolated antecedents that effect the probability of behavior. This also sometimes makes it difficult to identify antecedent events. For example, a person may be more likely to exhibit challenging behavior if he or she is criticized for doing something wrong, when they are ill or otherwise not feeling well. In this situation, there are two antecedents. The first is a more distant setting event, i.e., being ill or otherwise not feeling well, e.g., not getting enough sleep the night before; the other is a more immediate antecedent event, i.e., being criticized. Neither of these antecedent events may by themselves increase the likelihood of challenging behavior. When the person is feeling well, they may be very able to tolerate criticism without exhibiting challenging behavior, and as long as they aren’t criticized, they may be very able to tolerate not feeling well without exhibiting challenging behavior. It is only when both antecedents events occur in concert that the probability of behavior is increased. We often look for single antecedents rather than for multiple antecedents; which is why we often fail to identify the more typical multiple antecedents that exist.

Not Just In The External World. Traditionally, we have tended to limit our antecedent analysis to the external environment (i.e., who, what, where, when). But antecedent events can occur in three domains: organic/health domain, external domain, cognitive/mental domain. For example, we are sure you would agree that your everyday behavior is influenced by how you feel, whether you are feeling good or not, whether you are ill or not, whether you have had enough sleep, and whether you are in pain. Physical factors can play an antecedent role, in other words. Similarly, what you believe or how you perceive an event can influence your behavior. For example, if you were told that a person you had just met is manipulative, you might reject a present because you believed you were being manipulated. A parent might be more likely to punish their child more severely if they believe the child was being “willful.” And we might be more likely to react negatively to a misbehavior if we believe that the child did it “on purpose.” In other words, behavior is influenced by “cognitive antecedents.” Our lack of attention to organic and mental antecedents can be a major barrier to a good antecedent analysis, i.e., understanding the antecedent events that affect the likelihood of a behavior.

The Cart Before The Horse. An antecedent analysis should follow information gathering, it shouldn’t precede it. Often, the first question we ask is “...under what circumstances is this behavior more or less likely to occur.” Before we ask questions like these, however, we should first gather information about the time of day, place, activity, people, interactions, style, etc. that are observed to be occurring during or prior to an episode of challenging behavior. We would also want to know these things for when the behavior is not occurring. That is, we should describe before we analyze. After we describe the details of the situations we observe prior to and during specific behavioral episodes and the details of the situations we observe during specific times when the behavior is not occurring, then we can attempt to identify the events which tend to be present during or prior to an episode, but not otherwise, and those that don’t, but not otherwise. It is only at this point that we may be able to identify the events that have an antecedent relationship with the behavior.

...we should describe before we analyze.
time. An antecedent analysis should not only identify the antecedents associated with the higher and lower likelihood of the start of a behavioral chain, including its precursors, but also those antecedents associated with the greater likelihood that the episode will escalate and those antecedents associated with the greater likelihood that the episode will be relatively mild and be resolved relatively quickly. For example, the interactional style that parents or staff use may very well affect the escalating pattern of behavior, just as the escalating pattern of behavior may affect what parents and staff say and do and how they say it and do it.

For example, aggression i.e., hitting others, may be the last link in a behavioral chain that follows a typical course for a particular client:

a. Refusal to do a task.

b. Profanity and verbal threats.

c. Attempts to physically leave the environment.

d. Breaking and throwing objects.

e. Hitting others.

In this situation, an antecedent analysis should identify those things that are associated with a greater likelihood that behavior “a” will occur and those things associated with a greater likelihood that behavior “a” will not occur. However, given that behavior “a” does occur, an antecedent analysis would continue to identify those things that are associated with a greater likelihood that behavior “b” will occur and those things associated with a greater likelihood that behavior “b” will not occur; and given that behavior “b” does occur, identify those things that are associated with a greater likelihood that behavior “c” will occur and those things associated with a greater likelihood that behavior “c” will not occur; and so on. Further, this analysis would be necessary regardless of whether the referral problem was “Refusal to do a task” or “Aggression.” (If the referral problem was “refusal to do a task,” some of this may be included as part of the consequence analysis.) This complex, interactive, antecedent analysis would also need to follow, as described above, information gathering for the occurrence and non-occurrence of each of the separate components of the sequence, given the occurrence of the preceding component.

As we can see from the above, an antecedent analysis may be quite involved. However, it can be critical for developing an effective support plan. For example, knowing that criticism is an antecedent to challenging behavior, a comprehensive support plan could, among other things, include guidance to staff on how to provide corrective feedback to the person, positive programming strategies to teach the person more effective ways for tolerating and coping with criticism, as he or she is likely to experience in their interaction with other people, as we all do, possible incentives for using the new coping strategies, etc. That is, a comprehensive antecedent analysis can provide information that can be useful in avoiding or minimizing the occurrence of challenging behavior and helpful in telling us what skills may be useful to the person in their desire to break the barriers to social and community integration that their challenging behaviors may have created for them.

4. Consequence Analysis. Analysis in this area is designed to determine the possible consequences that strengthen or suppress the behavior or its alternatives. The questions that are addressed here include: a) What consequence(s) does the behavior have for the person; b) What consequence would be the removal of the behavior have for the person and for the key people in the person’s life; c) What is the reaction of other people to the behavior; d) What attempts have been made in the past the control or change the behavior; and e) how have these attempts been implemented and with what outcomes?

As with the antecedent analysis, the consequence analysis follows an information gathering phase in which we first ask what does happen following an episode of behavior, i.e., what occurs when the behavior occurs. Sometimes, something is added or gained after the occurrence of a behavior and sometimes something is stopped or avoided after the occurrence of a behavior. For example, we may observe and note that when the behavior occurs, people look at and/or come closer to the person, the person is given something to eat or something else, someone hugs, touches, or even physically restrains the person, the environment changes or is changed in some way, some problem is solved, a conversation begins, etc. Alternatively, perhaps a request is rescinded, the person is sent to a different area, an activity is discontinued, either temporarily or for the day, stress is reduced, the person is left alone, the radio or TV is turned off, etc. These events
may help us to identify the consequences that strengthen or suppress the behavior or its alternatives. Knowing and understanding these consequences can then contribute to an understanding of meaning.

5. Impressions and Analysis of Meaning. When a functional analysis is carried out within the context of a comprehensive behavioral assessment, including a thorough skills analysis, an analysis of the relevant background information, a motivational analysis, an ecological analysis, and a mediator analysis, it is time to infer the meaning of the behavior for the person. The concept of behavioral meaning is not new to the field of operant psychology. The meaning of behavior can be found in its consequences under certain conditions. The process of behavioral assessment and functional analysis is to understand those consequences and the conditions which surround them. The inference that is drawn from this process may conclude that the behavior is the person’s way, for example, of communicating, of relieving stress, of playing or otherwise interacting with others, etc. Other assessment approaches may also result in hypotheses or inferences about meaning, but they are either limited in the data base from which the inference is formed or the hypothesis is limited to an a priori set of possibilities that may be too broad or general to be helpful (e.g., Durand, 1990; O’Neill et al., 1990; Iwata, Dorsey, Slifer, Bauman, & Richman, 1982).

For example, to simply conclude that a person engages in a particular behavior to get out of or to avoid a task may lead to a much different support plan that one which was further informed by knowing whether such “task avoidance” behavior was influenced by how the request was made, by who makes the request, by what is being interrupted when the request is made. The support plan would also be strengthened by knowing what tasks, styles, circumstances, etc. make the performance of a requested activity more likely, not less likely to occur, i.e., those circumstances that lower the probability of the challenging behavior. Further, a comprehensive assessment leading to an inference as to the specific meaning of the behavior for the person, rather than ascribing a generic function to it from a limited list of a priori possibilities, reduces the possibility that a total misunderstanding may occur. For example, the non-performance of a requested activity, often labeled “noncompliance,” may indicate that the person doesn’t want to do what is being asked, (for one or more of any number of reasons), that the person doesn’t understand what is being asked, that the person doesn’t know how to do what is being asked, etc. In this case, to understand the meaning of the behavior requires more than just knowing that it occurs when a request is made. A complete analysis of their skills, an analysis of all the background information, an ecological analysis, and all the rest would be necessary for maximizing the likelihood that a correct inference can be drawn about the meaning of the behavior for that particular person.

The inference of meaning that is drawn from an assessment forms the basis for the development of a support plan, including both proactive (ecological, positive programming and focused support) and reactive strategies (LaVigna, Willis, & Donnellan, 1989; LaVigna & Willis, 1995). We believe that the effectiveness of a support plan is enhanced by the quality and comprehensiveness of the assessment that has been carried out and the validity of the inferences drawn as to the meaning of the behavior for the person. The ultimate test of the validity the assessment process and the resulting inferences is its contribution to the effectiveness of the support plan in producing the desired outcomes (LaVigna & Willis, 1995).

Summary and Conclusions

The contribution of an assessment process to the effectiveness of a support plan is referred to as its “treatment” utility, an area of research that is in its infancy in the field of challenging behavior (Ballmaier, 1992; Hayes, Nelson, & Jarrett, 1987; 1989). In that regard, the “treatment” utility of the assessment process described above has not yet been subjected to the most rigorous empirical tests. It nevertheless has face and content validity (Ballmaier, 1992). We believe this face and content validity will be increased as we expand different elements of this assessment process in more detail in future issues of this newsletter. Specifically, we are preparing articles that further elaborate antecedent analysis, ecological analysis, and mediator analysis. These have been the areas that people have seemed to be the most interested in having us elaborate. If there are other areas that you would like us to address, please let us know.

To summarize, their are two phases in the IABA behavioral assessment and functional analysis process. The first is a comprehensive information gathering phase, in which information is gathered through interviews and questionnaires, records review, direct observation, and interactions with the focus person. The second is the summary, synthesis and analysis of the information gathered in a formal assessment report following a particular format. The Behavior Assessment Guide (Willis et al., 1993) was developed to assist in this two phase process. In its fifth revision, the current 1993 edition provides both an informa-
tion gathering and records abstraction tool and a writing guide for preparing the formal report.

Earlier, we stated that we believed this process, when done correctly, was time consuming. Accordingly, to be used most cost effectively, it should be used when any of the criteria described in Part I have been met. We would like, at this time, to offer some additional suggestions for the organization of support services for people who have challenging behavior. We believe that if the following services are arranged, the need for the more time consuming and comprehensive process we have described here should be manageable within the resources that are typically available. Conversely, it is the lack of one or more of the following service features which taxes services and agencies and the staff that work within them. Which of the following does your system have and which doesn’t it have?

1. A carefully thought out and written service design and plan based on the principles of Social Role Valorization and current practices in the field that have been developed to help people of various ages and characteristics in a variety of home, school, work and community settings. For example, we have developed a supported employment service which we offer to those adults who have been referred to us for support during those hours that most adults work, i.e., Monday through Friday, nine to five. We have also developed a supported living service which we offer to adults who have been referred to us for residential support. In our supported living service, a standard, i.e., a designed (planned) element of that service is the development of a Positive Futures Plan (Mount & Zwernik, 1988; Patterson, Mount, & Tham, 1988; O’Brien & Lovett, 1992). In contrast to the typical agency or systems driven “Individualized service plan,” the Positive Futures Plan is driven by the person and their aspirations for the future. We believe that an agency that carefully thinks through how it wants to provide services, articulates its philosophy, and writes out its plan and design of services is not as likely to arrange situations that themselves may generate challenging behavior, and that service design and plan, we suggest a level of assessment and planning that may preclude the need for more formal and time consuming efforts. There are a number of assessment methods and strategies that do not require specialized training and that are very practical in terms of time and resources, that may provide a critical mass of information to form the basis for designing an effective support plan employing both proactive and reactive strategies (LaVigna and Willis, 1995). This could be carried out by people who are at or very near the direct service level, such as classroom teachers, group home staff, etc. It would involve such strategies and methods as A-B-C (antecedent-behavior-consequence) analyses, the MAS (Motivational Assessment Scale [Durand, 1990]), the O’Neill et al. (1990) process, scattergraph analysis (Touchette et al., 1985), use of a communication grid (Donnellan et al., 1984), reviewing speech and language assessments, reviewing psychological assessments, etc. This level of assessment may also include the collection of information using the Behavior Assessment Guide (Willis et al., 1993), precluding the summary, synthesis, and analysis of this information in a comprehensive assessment report. To pickup again on the puzzle metaphor that we introduced in Part I, sometimes it is possible to tell what the picture is when only some of the pieces have been gathered and put together. We believe that an agency that incorporates into its design of services, methods for determining the meaning of a person’s behavior and the function it serves and explicit guidelines for the development of multilevel support plans based on this person centered understanding of behavior, is more likely to resolve problems than one that does not.

2. For those people whose challenging behavior persists in spite of the articulation of a coherent philosophy and service design and plan, we suggest a level of assessment and planning that may preclude the need for more formal and time consuming efforts. There are a number of assessment methods and strategies that do not require specialized training and that are very practical in terms of time and resources, that may provide a critical mass of information to form the basis for designing an effective support plan employing both proactive and reactive strategies (LaVigna and Willis, 1995). This could be carried out by people who are at or very near the direct service level, such as classroom teachers, group home staff, etc. It would involve such strategies and methods as A-B-C (antecedent-behavior-consequence) analyses, the MAS (Motivational Assessment Scale [Durand, 1990]), the O’Neill et al. (1990) process, scattergraph analysis (Touchette et al., 1985), use of a communication grid (Donnellan et al., 1984), reviewing speech and language assessments, reviewing psychological assessments, etc. This level of assessment may also include the collection of information using the Behavior Assessment Guide (Willis et al., 1993), precluding the summary, synthesis, and analysis of this information in a comprehensive assessment report. To pickup again on the puzzle metaphor that we introduced in Part I, sometimes it is possible to tell what the picture is when only some of the pieces have been gathered and put together. We believe that an agency that incorporates into its design of services, methods for determining the meaning of a person’s behavior and the function it serves and explicit guidelines for the development of multilevel support plans based on this person centered understanding of behavior, is more likely to resolve problems than one that does not.

3. We believe that agencies that follow the suggestions above will find that the number of referrals for a more comprehensive assessment will be sharply reduced. However, we would like to suggest one more set of recommendations which can reduce the number of people who would meet the criteria described in Part I for a full assessment. This additional but critical recommendation would be the development and implementation of a quality management system, such as the Periodic Service Review (PSR) system (LaVigna, Willis, Shaul, Abedi, & Sweitzer, 1994), that assures the consistent implementation of a both general and individual service plans. Many agencies already have written service philosophies and service designs and plans and/or make some effort at functional analysis and understanding the meaning of behavior and design some degree of multilevel support plans, as evidenced by a written plan. However, our experience with hundreds of agencies and
what many more hundreds of agencies report to us is that a very small percentage of a written plan, either general or individual, moves from paper to practice. For an agency that is considered good, the expectation of implementation may be anywhere from 35% to 50%. That is, good agencies move 35% to 50% of their general and individual service plans from paper to practice. Accordingly, even if you are a good agency, with a written philosophy and service plan and with individualized support plans based on some reasonable methods of assessment, you will have excessive numbers of people who meet the criteria for referral for a comprehensive assessment, unless you have a total quality management system in place, such as the PSR, to assure consistency and quality in staff’s provision of services and in the implementation of service plans.

We believe that if the recommendations described above are followed, most systems would have the resources to carry out a full assessment for the remaining people who meet one of the three criteria. However, we would suggest that this comprehensive assessment, including both the information gathering phase and the analytic report writing phase (Willis et al., 1993), be carried out by a qualified person who has been trained to carry out this process. Further, we suggest that, if possible, this not be the person who has carried out the less comprehensive assessments for the person being referred. This is because other assessment processes may have led to some preconceptions about the meaning of the behavior.

The comprehensive assessment process we have described above requires that conclusions about function are reached after the information has been gathered and analyzed, rather than starting the process with preconceptions and expectations. The person needs to be able to see past such premature, con–clusionary labels such as “noncompliance,” “inappropriate attention seeking,” “self stimulation,” “task avoidance,” and the like. Conclusions about function and meaning should come as a result of the assessment process rather than serve as its starting point. This may be difficult for someone who has already reached a conclusion using a different, perhaps less comprehensive assessment process than the one being recommended here as part of our model for breaking the barriers to social and community integration (LaVigna and Willis, 1995).

References

Severe and Challenging Behavior: Counter-Intuitive Strategies for Crisis Management Within a Nonaversive Framework

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Editors’ Note: The Multielement Model has evolved gradually over the years. One of the areas that has developed most dramatically has been that of reactive strategies and emergency management of and for behavioral crises. While those of you who have attended our two-week training institutes and longitudinal training programs would have received a copy of our monograph concerning Emergency Management Guidelines, we have totally revised that monograph and plan to publish it later this year as Challenging Behavior: Reactive Strategies and Emergency Management Within a Nonaversive Framework (Willis & LaVigna, in press). The following article presents some of the material we discuss in the monograph and is based on a presentation Gary gave at the Positive Programming Conference sponsored by St. John of God in Dublin, Ireland, in April 1995.

Applied behavioral analysis has been very useful in the development of positive approaches for supporting people with severe and challenging behavior (LaVigna & Donnellan, 1986). In fact, the nonaversive strategies that have been developed are based on the same fundamental premise as the punitive strategies; that behavior is a function of its consequences, under certain conditions. In the research that has been carried out in both the experimental analysis of behavior and applied behavior analysis, we have not seen a single piece of evidence, a single study, a single sentence that would support a conclusion contrary to the following statement: If you have a behavior that could be changed through the use of aversive contingencies, then it could also be changed through positive contingencies. Our confidence that this statement is true, your belief that behavior can be changed through positive strategies, as well as punitive ones, has helped evolve the field of Positive Practices.

As that field developed, many of us became concerned that something was being lost; something was missing in what we were doing. What was it? The answer is, “The PERSON.” When you think about the thousands of behavioral studies that were published beginning in the 60’s through the 90’s, you probably recall those the graphs which showed such dramatic decreases in the TARGET behaviors. The tragedy, however, is do you remember anything about the PERSON, the SUBJECTS? Probably not. Do
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you remember why they did what they did; was it even reported? Probably not.

Someplace, we lost sight of the most important part of what we do and why we do it; the PERSON. Yes, we have the technology to change behavior, but why are we doing it, and do we have the right? We believe we are doing what we do to help people improve the QUALITY of their lives.

...giving our analysis a person centered focus has helped us understand that what we often call problem behavior always serves some legitimate function for the person.

As a result of these concerns, WE and others; namely, you have endeavored to turn our focus toward the PEOPLE we serve. We have begun to ask why people do what they do; why they hurt themselves and others. Most importantly, giving our analysis a person-centered focus has helped us understand that what we often call problem behavior always serves some legitimate function for the person. Additionally, this person-centered focus has resulted in looking beyond behavior; looking at valued/meaningful outcomes for the people we serve.

A value-looking, values-based approach to people with disabilities and challenging behavior is not new. The Social Role Valorization movement has caused us all to focus on helping the people we serve achieve valued and valuable outcomes. Unfortunately, an artifact of this values-based approach for many has been the unnecessary rejection of behavioral technology.

Behavioral technology, however, can be used in support of and in subordination to values. As we have described elsewhere (LaVigna & Willis, 1996), our values were strongly influenced by Wolfensberger (1983). We value: community presence and participation, in ways that are age appropriate and valued by society; autonomy and self-determination, through the exercise of increasingly informed choice; continuous involvement in the ongoing process of becoming; increasing independence and productivity to the point of economic self-sufficiency; and the opportunity to develop a full range of social relationships and friendships.

These values serve as a foundation for the work we do with the people by IABA. With these values in mind, we have developed a model for supporting people with challenging behavior, which is aimed toward producing several outcomes (LaVigna & Willis, 1995). Where necessary, when it is a very dangerous behavior, one of the things we need to be concerned about is getting rapid results. So, speed and degree of effects is one of the outcomes we are interested in producing. Second, we want durability. We want lasting change. Third, we want those changes to generalize to other settings, particularly to the community and the other natural settings that others have an opportunity to access and enjoy. We want to minimize the development of negative side effects. Accordingly, we track collateral behaviors. We also want to use strategies that have social validity, that is, those strategies that are acceptable to our client, our client’s family, support staff, and the community.

Finally, we need to demonstrate that what we do has educational and clinical validity. This means that as a result of what we have done, we can show that the person has a better quality of life; the person is happier, has greater access, greater opportunity, greater control, etc. That is, we have achieved our valued outcomes. When we are designing our support strategies, it is this entire breadth of desired outcomes that we focus on. No one of these dictates what we do at any given time. We discipline ourselves to stay focused on the entire range of needs.

To achieve all of these outcomes, we begin with a person-centered assessment aimed at understanding the meaning of the behavior (Willis & LaVigna, 1996a; b). This involves a broad look at the person’s life situation and not just the immediate antecedents and consequences of their behavior, his or her skills, family, history, health, environments, etc. This is all in an effort to get a very broad understanding of the meaning of the behavior for that individual. On the basis of this broad understanding, we design a multielement support plan. These plans include proactive strategies, including ecological changes, positive programming and focused support, designed to produce changes over time and where necessary reactive strategies, to deal with situations when they occur. The plan is then implemented by a support team with management systems effective enough to ensure consistency (LaVigna, Willis, Shaull, Abedi & Sweitzer, 1994). This is the multielement model that integrates our effort to produce the full range of outcomes, guided by the values described above (LaVigna & Willis, 1995).

One of the significant technical challenges in working with people who do have severe and challenging behavior is in dealing with crisis situations when they occur. The person is breaking windows now, the person is starting to bite himself now, the person is throwing furniture at other people now, the person is biting, kicking or scratching others now. It is relatively easy for us to agree to use strictly positive, nonaversive strategies in the proactive mode, but we tend to get more challenged in coming up with strategies in the reactive mode that are equally positive.

The multielement model can help liberate some very creative, equally positive, reactive strategies. It provides access to reactive strategies that we previously never thought we had. Using the multielement approach, we construct our proactive plans to produce certain changes over time. Accordingly, when we are planning what to do about a behavior when it occurs, we are liberated from needing to address the issue of the future. Our sole agenda becomes situational man-
management. This gives us options that in other contexts might produce counter-therapeutic effects.

Here is one brief example of an early experience of ours that led us to become aware of the new options that might be available to us in using the multielement approach. We were asked to carry out an assessment for a man a number of years ago who had a very serious form of self-injury. We’ll describe it, not to be disrespectful to him, but for you to appreciate the seriousness of the behavior and why people needed to do something when it was occurring. When he got upset, he would tug on his own lip to the point where he had separated it from his face on a number of occasions, requiring surgical replacement. The doctor was saying that we could not let it happen anymore because he did not know how many more times he could successfully sew his lip back into place. We carried out our assessment and we designed a multielement plan. In terms of proactive strategies, there were 18 different things that we included, i.e., 18 different ecological, positive programming and focused support strategies.

The question, of course, was what were we going to do when he started tugging at his lip? In designing a support plan, in many cases, we may need to anticipate some level of occurrence of the challenging behavior. The best we could come up with to keep him safe when he started tugging at his lip was to put our arms around him and hold him. You might expect that holding him was an aversive event. However, the problem was just the opposite, since being held in this manner was a reinforcing event. Perhaps some of you have worked with people for whom being physically held and restrained is a reinforcing event rather than an aversive one. The position that this person put us in was that what we were doing to keep him physically safe was potentially reinforcing the problem behavior. This could have produced a counter-therapeutic effect, which would have made the behavior more likely to happen in the future.

Using the multielement model, there is a certain logic in “holding him when he engages in self-injurious behavior.” The logic is this: The reactive strategy is used to get the most rapid and safest control over the crisis situation. If this reactive strategy has potentially reinforcing properties, the counter-therapeutic effect can be prevented by including certain other strategies in the proactive plan. Specifically, these can include the independent and noncontingent availability of the event used as a reactive strategy, supplied at satiation levels. By taking these proactive steps, the reactive strategy merely gives us a very effective means of dealing with the situation without producing a counter-therapeutic effect.

In the case at hand, to assure the proactive, noncontingent availability of the event, five minutes every half hour was scheduled to assure that staff provided him with a deep muscle massage. The reason for this is that we did not want his intense physical contact with staff to be accessible to him only through the problem behavior. We want you to be very aware of this safety valve built into the proactive plan. What happened over time was that years later, he still has his lip. Further, because of the proactive plan, he no longer engages in any level of self-injurious behavior. What we see here is a reactive strategy which was actually a reinforcing event that, in addition to being used as a reactive strategy, was provided at other times on a noncontingent basis. This provided a very effective situational management strategy when the target behavior occurred and yet was able to do so without producing a counter-therapeutic effect. What we have learned is that the multielement model allows these kinds of options.

We want to discuss how we address this need for management strategies in situations that might be considered to be of a crisis nature. This is important since many of you are working with people whose behaviors can occur at crisis levels, where health and/or safety are at immediate and serious risk. There are many reactive strategies that we could employ that are not particularly counter-intuitive or which are perhaps more appropriate for more innocuous non-crisis problem behavior, which we discuss in full elsewhere (Willis and LaVigna, in press). What we thought would be a good focus for this paper is to discuss strategies that may seem extremely strange, until you have become fluent in using the multielement model. Your first reaction when we mention some of these strategies will be “that sounds absolutely crazy.” That is what we mean by counter-intuitive; at first glance they just do not seem to make sense.

Since the best crisis management strategy is one that prevents crises to begin with, we’ll start with some counter-intuitive strategies for preventing crises and then we’ll turn to some counter-intuitive strategies that are remarkably effective in getting rapid control over crises when they are actually occurring.

**Preventing Behavioral Crises**

Let’s begin with some counter-intuitive strategies for preventing or avoiding crises. Remember that the context for this discussion is rooted in thinking about those people whose behaviors can escalate to crisis levels.
because we wouldn’t want to reinforce the problem behavior.

Consider this, however. Have you ever had this experience as a parent? It is late Saturday afternoon, your sweet, adorable, angelic child comes up, saying something to you and because of nothing having to do with that child or what that child did, you snap and snarl and are mean to that child. Even as you are acting in this horrible parenting way, you are saying to yourself “she doesn’t deserve this.” You know your behavior has something to do with having nothing to do with the child. The child is totally innocent and you are not able to convince yourself that she deserves the way you are acting towards her. How many of you, then, realizing this is uncalled for behavior on your part, canceled that evening’s plans, called up your friends and said: “Sorry, I can’t go to the movie today.” “I know we were supposed to come over for dinner tonight but I’m afraid that if I go over and enjoy myself, I am going to inadvertently reinforce this terrible parenting behavior.” None of you did that. Why didn’t you become a terrible parent? That is, why wasn’t your problem behavior reinforced and strengthened. For two reasons; first, the reinforcing event was not a contingent event. It is not as if “I’m going out to dinner tonight because I was mean to my child.” Second, there was a delay between the event that happened in the afternoon (your behavior) and the (reinforcing) event that happened in the evening.

We know that for reinforcement to strengthen behavior; it has to be immediate and contingent. As long as there is a sufficient delay and/or if there is no contingency relationship, then we shouldn’t have to worry about going ahead with an independently scheduled, noncontingent reinforcement. Such a reinforcing event should not strengthen problem behavior, even if the behavior occurred earlier in the day.

There are many reasons for maintaining a high-density of noncontingent reinforcement. Consider this; a high density of reinforcement may be a setting event for the low rate of challenging behavior, whereas a low density of reinforcement may be a setting event for a higher rate of problem behavior. So, by initiating, or by introducing, a high density of reinforcement, we are creating a pervasive setting event which by itself should reduce the level of challenging behavior and behavioral crises.

Furthermore, when we cancel the evening’s plans because we are afraid that the problem behavior is going to reinforced, we introduce an aversive event; namely, the withdrawal of a reinforcing activity or reinforcing event. This withdrawal itself can trigger a crisis situation. Rather than acting in a way which minimizes the likelihood of a crisis, when we cancel that evening’s event because of a problem behavior, we immediately have done something that makes a crisis more likely, not just because a low density of reinforcement is a setting event for a higher probability of challenging behavior, but also because the withdrawal of the reinforcing event itself is a type two punisher and can very likely elicit a problem behavior.

Perhaps the greatest reason for maintaining a high-density of noncontingent reinforcement is its impact on the quality of life of the individual. Consider the quality of life of the people we serve who also have challenging behaviors. At best, it does not approximate ours at its worst. Surely, setting the conditions for a low-density of reinforcement does not improve a person’s quality of life. If one of our goals is to give people a better quality of life, one of the most direct ways of doing this is to introduce a higher density of noncontingent reinforcement that just improves the quality of life generally. It is our contention that in whatever we are doing to support a person, we should be able to demonstrate that the person is experiencing a higher density of reinforcement than before we got involved. A high density of reinforcement should be noncontingently available to a person before we even consider any contingencies in which the person has to earn reinforcement. We don’t have to earn most our pleasures in life; then, why should they?

Consider this example. We were working recently with a 14-year-old girl whom we had just helped move home after being in a 24-hour residential school, where she had been for the previous four years. She moved home on her parents initiative because what they were using in the 24-hour facility, among other things, was a restraint procedure. Now that she had gotten to be an old and big 14-year-old as opposed to a young and small 10-year-old, the kind of restraint procedure they were using was leading to injury. Further, it was no longer acceptable to the funding educational authority.

She came home and we established a multi-element support plan. One of the things we knew about her was that she had very poor impulse control and, for that and a variety of other reasons, we recommended that we introduce and maintain a high level of noncontingent reinforcement, independent of what she did or didn’t do. One of the things she did right from the very beginning was to not go to school every day. When she would stay home from school, how would we spend the day? We didn’t insist that she stay home as you might with a typical child. You might say, “If you don’t go to school today, then you can’t go out and play.” With her, we got out of the house;
we went into the community; we did a variety of things, including on one occasion stopping and buying a snack.

The question to us could be “weren’t we concerned that we would be reinforcing her refusal to go to school?” That’s a legitimate question to ask. We had reason to think that we would not be differentially reinforcing that behavior because community access was something she was enjoying every day anyhow, buying snacks in the community was something she was enjoying every day anyhow. These were not contingent events. Further, we knew that when she got to school, she really enjoyed the activities that were there and even though we might be out in the community doing things, what she was not getting access to were some of the activities she really enjoyed at school. It may be a high density of reinforcement should she choose not to go to school, but we believed it would be an even higher one if she chose to go.

Part of the monitoring system here is not just to determine whether or not we were avoiding severe property destruction and aggressive behavior, her target behaviors. Obviously one of the things we were also tracking in our evaluation system was time spent in school. Sure enough, over time she spent more and more time in school. Obviously this needed to be tracked and we needed to plan these things with care, based on all the information that we had gathered in our assessment process.

To summarize, introducing and maintaining a high density of noncontingent reinforcement can help prevent behavioral crises. The avoidance of a behavioral crisis can be made more likely since a high density of reinforcement is a setting event for a lower probability of problem behavior. Further, not canceling a reinforcing event avoids an aversive event which itself can increase the likelihood of target behavior and/or escalation to a behavioral crisis. This recommendation also normalizes the density of reinforcement experienced by the people we support by providing a density closer to the norm and by removing artificial contingencies. This recognizes that most of our day-to-day reinforcers are also noncontingent. Possible counter-therapeutic effects can be prevented by assuring the noncontingency of the reinforcing events, making sure to schedule their occurrence independent of the occurrence of target behavior. Other concerns about counter-therapeutic effects can also be addressed through the proactive plan in a multielement approach.

**Avoiding Natural Consequences.** Another counter-intuitive strategy for preventing a behavioral crisis is to avoid some natural consequences. This suggestion may sound strange to many of you. It may even be objectionable for people who take an explicitly values-based approach who may rely heavily on natural consequences to promote the quality of the lives of the people they serve. But, we feel there are a number of good reasons for avoiding SOME naturally occurring consequences. Consider this, if the natural consequence is aversive for the person, it may escalate the person’s behavior to a potentially crisis level. In addition, consider that the natural consequence can itself lead to further exclusion and devaluation. When natural consequences have the potential for causing crisis level escalation, and when they further stigmatize the person, we suggest that maybe we should avoid the natural consequence.

Here is an example of the problem. We were supporting a woman in her job and we knew she was on the verge of quitting. She went in and she quit. Fortunately, her boss didn’t say, “You can’t quit. You’re fired.” She had a chance to avoid being fired with our guidance. This is counter-intuitive since many of us would say “Let her experience the natural consequence. That is how she’ll learn.”

The proponents of natural consequences argue that the people we serve have the right to these consequences and that we devalue them by not providing them. They ask, “What is wrong with natural consequences? I experienced them and I turned out OK.” If there is one thing that characterizes the people we are discussing today, it is they are not going to learn from their natural consequences. If they were going to learn from natural consequences, this newsletter wouldn’t exist. We’d be working in a different field. We’re talking about people who characteristically have not and will not learn from natural consequences. It seems to us that the proponents of natural consequences are arguing two points. First, they seem to be saying that the people we serve would be OK today if people would have “just used natural consequences from the get go.” Second, they seem to be saying that parents and teachers FAILED to use natural consequences, and that is why their adult children misbehave. That is just not the case. Parents and teachers usually began trying natural conse-
quences. That didn’t work so they got a little more contrived in what they did. That didn’t work so they called in a consultant and it got even more contrived. As they got more and more contrived, they probably got more and more punitive and more and more segregated and isolated. So, by the time that child was an adult; she was in a strict program, isolated and segregated from the rest of society.

For the past fifty plus years, all of us have been striving to liberate the people we serve from the degradation, isolation and abuse they experienced in segregated places. The proponents of natural consequences seem to be saying, “Now that they have been liberated, let us use natural consequences to manage their behavior.” It seems that they are suggesting that we go back to “square one;” back to the ineffective things that were tried by parents and teachers when their children and students were very young. Unfortunately, it seems to us that this would be just starting the “cycle of escalation” all over again.

We caution you, be careful of natural consequences and avoid them where they may lead to crisis situations or to further exclusion and/or devaluation. In any event, don’t expect the occurrence of natural consequences to be an effective teaching strategy for the people we are concerned about. It’s the people who don’t have severe and challenging behavior who may have learned from natural consequences, not the people whom we are concerned about here.

Don’t Ignore Behavior Under Certain Conditions. How many people have heard of Guido Sarducci? Guido Sarducci established a 20 minute university in which he teaches in twenty minutes what the typical college student remembers five years after they have graduated from college. His idea is why teach all that other stuff if all they are going to remember is 20 minutes worth of information. That is all he teaches them to begin with. So in Economics 101, he teaches “supply and demand” because that is all we remember from Economics 101 five years after we have graduated.

What do we remember from our Introduction to Behavior Modification course? What we remember is that when a person acts inappropriately, that we should ignore. How many of you have ever heard this phrase? Ignore her; she is doing that for attention. We’ll bet you that this phrase was not used with reference to a peer or a colleague, but that it was used with reference to one of our clients.

How many of you really believe there is something to the idea that aberrant behaviors communicate legitimate messages? Most of us do. If that is true, what is worse than to advise somebody to ignore the behavior? What you would be saying functionally is to ignore their efforts to communicate. What happens if you ignore a person’s communication? The person’s behavior escalates.

We have talked about precursor behaviors before; you know, those minor behavior problems, those low levels of agitation that may signal that the person is preparing to engage in something serious. These precursors might be understood as the whispers of behavior. Because of what we remember from the Sarducci school, we ignore them. Consequently, what are we requiring of the person? It seems to us that we are requiring that the person not whisper to us, but shout at us; and it is the “shout” we then call severe and challenging behavior.

The consultant you are likely to hire off the street for advice on what to do with problem behavior is likely to say ignore it. However, if you want to avoid crises, good advice may be don’t ignore it. But there are some qualifications to this advice. In the first place, ignoring doesn’t always equate to extinction and it is really the extinction event that causes the escalation (the opposite effect we look for in a reactive strategy in a multielement approach). Table 1 provides definitions of extinction and ignoring and corresponding examples of when ignoring represents extinction and when it doesn’t.

Don’t Punish. Our final counter-intuitive strategy for preventing behavioral crises is don’t punish. We have worked with a number of large service delivery agencies over the past twenty or so years. During that time, we have seen two very large agencies simply abandon punishment altogether after our training; overnight, by fiat. No more punishment al-

**Definitions:**

**Extinction** - The withholding of a previously available reinforcer.

**Ignoring** - Continuing with what you were doing as if the behavior had not occurred.

**Example #1:** When ignoring is extinction.

**Scenario** - A teacher has been reprimanding the student and sending her to the vice-principal’s office whenever she uses profanity in the classroom. He observes that the behavior is getting worse and not better and concludes that contrary to his intentions he has been reinforcing this behavior. For one thing, the student seems to enjoy getting the teacher upset. Secondly, the student seems to like missing class. Accordingly, the teacher plans to start ignoring this behavior, thereby with holding the previously available reinforcers.

**Immediate likely effect on behavior** - Escalation.

**Advice when using a multielement approach** - Don’t ignore.

**Example #2:** When ignoring is not extinction.

**Scenario** - During class time, a nine-year-old student challenged with problems associated with autism, frequently holds his open hand between his eyes and the lights on the ceiling and moves his hand back and forth. The teacher believes that it is the visual stimulation that is reinforcing the stereotypic behavior. She decides to ignore it when it occurs and simply continue with her instructional program as if it had not occurred.

**Immediate likely effect on behavior** - Ignoring the behavior will not escalate it and continuing with the instructional program may naturally redirect the student to engage in the instructional activity.

**Advice when using a multielement approach** - Since ignoring the behavior will not lead to an escalation in the behavior, this may be an option to consider. However, other reactive strategies may be necessary to get rapid and safe control over the situation.

**Table 1 - Extinction and Ignoring**
resolved! You might expect that once the punishment was stopped so quickly, there would be a tremendous “recovery after punishment” phenomenon; you might expect that all of a sudden high rates of challenging behavior would begin to occur. Yet when these agencies said “no more punishment allowed” the overall level of behavior problems decreased immediately and what remained were less serious problems.

Consider why that may be. A person acts in a way that is considered inappropriate. Let’s say there is a low level punisher available, loss of tokens, loss of privileges, cancellation of an event, etc. The person reacts to that with some agitation, some acting out, which gets another level of punishment. Now we might provide for an over correction procedure or some kind of time out procedure. Let’s say the person is not so happy about the over correction procedure or doesn’t want to be escorted to the time out room, and now starts to physically resist the effort to put them into that situation. What happens is that now staff are having to use physical management, restraint and other very extreme aversive procedures in order to finally control the behavior. While it is true that if you do not punish that very first behavior in the sequence, that behavior may increase in its frequency, what we may have avoided are the more serious behavior problems, the behavioral crises that result purely from our use of punishment.

One way to avoid crises are to eliminate punishment from our support plans. This is counter-intuitive since we think of punishment as a strategy for suppressing problem behavior. The suppressive effects of punishment, however, are future effects. In the context of situational management, punishment can escalate the situation, producing the opposite effect that we look for in a reactive strategy in a multielement approach. We have also discussed how introducing and maintaining a high density of noncontingent reinforcement, being very careful with our use of natural consequences, and not ignoring behavior under certain circumstances, while counter-intuitive, may also be very helpful in preventing behavioral crises. But what about the crisis that you can’t prevent? What about 2 o’clock Saturday afternoon when he starts to break every piece of furniture in the house? What can you do?

**Resolving Behavioral Crises**

*Diversion to a Reinforcing or Compelling Event or Activity.* Let us introduce you to two counter-intuitive strategies for resolving behavioral crises. The first is diversion to a powerfully reinforcing or compelling event or activity. That is, when the person is starting to act up, divert him or her with the most powerful reinforcing or compelling activity or event you can identify. For example, in the previous case of the person who was engaging in the lip pulling behavior, our holding him was an inadvertent reinforcing event. We didn’t design it to be reinforcing, but it certainly had the potential to produce a counter-therapeutic effect. As you may recall, to prevent this, we had to balance this reactive strategy by including certain features in our proactive plan.

Let us point out the intuitive part of this approach. What is intuitive is that if you introduce a dramatically reinforcing or compelling activity or event, it is not surprising that it can divert the person from whatever he is doing. What is counter-intuitive about it is that this would appear to result in the potential reinforcement of the problem behavior. This is the part that is counter-intuitive and appears, therefore, to contraindicate it as a useful reactive strategy.

If we didn’t have the multielement model, there would be no hope of using this strategy as part of a rational support plan. With the multielement model, however, what we end up with is a proactive plan that compensates for the potential counter-therapeutic effects of the reactive strategy, leaving us with a reactive strategy that doesn’t produce any unwanted changes over time but rather gives us a very effective way of dealing with a crisis situation when it occurs.

We want to give you a further example of this. In one of our training programs, We were guiding a teacher who had selected one of her students to provide a focus for her practicum assignments. Her recommended proactive plan included, among other things, changing her curriculum and reorganizing her educational space so it was less distracting. In terms of positive programming, her instructional staff were teaching her to use a picture communication board with which, for example, she could point to a picture of a glass of water if she wanted to drink something and she could ask to go to the girls’ room, ask for a magazine, and ask for break time by pointing to associated pictures. They were also teaching her the relaxation response, that is that when she was getting upset, to take a deep breath, hold it and relax. As a focused support strategy to produce rapid change in her problem behavior, they also had designed a particular schedule of reinforcement.

Then the question came up: “What do we do when she engages in the target behavior of screaming and scratching her own face?” Staff wanted to continue to use “corner time out,” but we pointed out to them that this appeared to be an ineffective reactive strategy insofar as they had been using it with little results. They were still getting an average of 40 minutes a day of the screaming and scratching behavior after 18 months of trying to solve this problem. We invited them to go back to their assessment information and identify, if they could, a behavior that
was reinforcing or compelling enough that it would interrupt almost anything. What they realized was that if they handed her a magazine, what she “needed” to do was open it and take the staples out. At the moment, that seemed to override everything else in her life. So the recommendation was that the minute staff saw the tantrum coming, they should hand her a magazine.

You would be concerned about two things in following such advice. First, you would be concerned that you would just be reinforcing tantrum behavior and increasing its future occurrence. The other thing you would be concerned about is that she would be with her magazines all day long and wouldn’t participate in any educational activities. So to make a long story short, the results were that from day one no day had more than five minutes of screaming and tantrums, representing an immediate and significant reduction in duration. We also tracked her on-task educational time. That also started increasing from day one. There was never a reduction in time spent in productive education. Further, the frequency of tantrums gradually decreased and by the end of the school year tantrums were no longer occurring. Therefore, it was no longer necessary for staff to hand her a magazine as a reactive strategy, since, with the elimination of the target behavior, a reactive strategy was no longer necessary. The last report we had was that it had been two years since there had been any tantrums.

Notice the safety valves included in the support plan. She could ask for a magazine using the communication board. She could ask for a magazine on the communication board.

Further, in the play area, where she was at least twice a day, was a stack of magazines, with which she could do anything she wanted. Such safety valves (i.e., independent, noncontingent access) allow using reinforcing and/or compelling activities and events to divert a person and interrupt a problem behavior, perhaps even problem behavior occurring at a crisis level, as a reactive strategy, without producing a counter-therapeutic effect.

**Strategic Capitulation.** Last, and perhaps most counter-intuitive of all reactive strategies is what we call **strategic capitulation.** Many times we know what the message is. We know what the person is asking for. We know what the person wants. When you know what the person wants, it is obvious that the quickest way to get him to stop asking for it is to give it to him. Capitulation!

Let us give you a very dramatic example of this involving a man on whose behalf we provided some consultation (LaVigna, Patterson, Willis, & Johnson, in preparation). His behaviors were quite serious. His aggression was so severe that his staff were often out on disability leave due to the injuries they had incurred. His self-injury was so severe because of his banging his head into the corners of walls and furniture; they were afraid he was going to be permanently blind, suffer severe neurological damage or possibly even kill himself. After a year of using a nonaversive approach, he was still considered to be an extreme risk to himself, so much so that the clinical supervisor thought contingent shock was necessary.

To make sure that they had their strategy right; they brought in an independent behavioral consultant with excellent credentials. After he did his assessment, he concluded the following: In spite of the fact that “state of the art” nonaversive procedures had been used, he concluded that this person remained a serious danger to himself and others. He suggested that not only were staff ethically justified in using contingent shock to treat this behavior, they were ethically required to use contingent shock to treat this behavior because this person has the right to effective treatment.

We were also asked to carry out an independent assessment. We concluded quite differently and felt that his behavior served a very obvious function. One of his precursor behaviors was to say “ba ba ba ba,” along with a backward swaying motion of his hand as he turned away from you. We also asked the staff, “In your experience, is there anything you can do when he is hitting you or hurting himself that if you do it he stops?” Their answer was “Yes, when we walk away he stops.” We concluded that the meaning of the behavior was “Leave me alone!”

The clinical supervisor had told them not to walk away or back off when target behavior occurred, since that would (negatively) reinforce the problem behavior. In fact, outside of the context of a well-balanced multielement support plan, counter-therapeutic effects, i.e., the reinforcement and strengthening of the target behavior, might very well have been the result. However, in this case, we recommended that capitulation be used as a reactive strategy as a strategic element in a comprehensive multielement plan. Along with the reactive use of capitulation we also recommended a variety of proactive environmental, positive programming, and focused support strategies, which among other things involved teaching him to tolerate performing non-preferred activities, teaching him to tolerate the presence of others, and teaching him to access the community. What we asked staff to do when he started hitting them or himself was to turn and walk away. The end result was that from that day forward, injuries stopped occurring. Staff were not longer hurt. He was no longer hurt. Further, beyond the dramatic reductions in the rate and severity of his self injury and aggression, his quality of life was also greatly improved.

We want to give you some guidelines for using capitulation strategically as a reactive strategy for target behavior to avoid escalation to crisis levels and/or
getting a crisis under rapid and safe control (Willis & LaVigna, in press). In these guidelines you will also see some advice for using some of the other counter-intuitive strategies.

1. If you are going to use capitulation, the earlier you use it the better. Ideally, this would even be in response to precursor behavior.

2. Whether the reinforcement that you have identified as operative is positive or negative, it should be made freely available to the person, simply for the asking.

3. Have a fully developed proactive plan which, among other things, is aimed at: a) improving the person's overall quality of life; b) giving the person more control over her or his life; c) teaching the person how to communicate; d) teaching the person how to cope; e) preventing negative side effects of reactive strategies; and f) reducing the need for any reactive strategies by using focused support strategies.

4. Design an adequate and accurate data system to measure effects on both target behavior and relevant collateral behavior.

5. Address social validity issues, including obtaining the collaboration and consent of the individual and all those who will be affected by the capitulation.

The toughest part of using counter-intuitive strategies to avoid and/or resolve crises is the social validity of those strategies. As effective as strategies such as these may be in establishing rapid and safe control in a crisis situation, getting people to accept them can sometimes be difficult. There may be many reasons for this resistance but we believe that one of them is that these strategies do not meet one of the needs that the use of punishment often meets so well. Whether punishment sufficiently changes the person’s behavior or not, the use of punishment meets our own emotional needs in many situations. Recognizing and dealing with this issue may end up being the biggest challenge in adopting a strictly nonaversive approach. Certainly, our experience tells us that counter-intuitive strategies such as we have described here can prevent behavioral crises or get them under rapid and safe control within a strictly nonaversive, multielement approach.

References
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Episodic Severity

An Overlooked Dependent Variable in the Application of Behavior Analysis to Challenging Behavior

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Abstract: Although applied behavior analysis has made a significant contribution in the area of challenging behavior, to date, researchers have not systematically investigated the episodic severity of behavior as a dependent variable. Episodic severity is defined as the measure of intensity or gravity of a behavioral incident. Research up to now has investigated changes in behavior over time, but not the degree to or speed with which a behavioral incident can be safely resolved. As a result, practitioners have had to look beyond applied behavior analysis to emergency management systems such as Mandt, Nappi, CPI, and the like, which have not been empirically tested. This article proposes including episodic severity as an additional dependent variable to enhance the social validity of behavioral plans and discusses the resulting implications for new terms and strategies.

Applied behavior analysis (ABA) involves the application of the principles and procedures of behavioral psychology to human behavior in all settings (Vollmer et al., 2000). Based largely on Skinner’s operant paradigm (1953), ABA is characterized by objectively and reliably measured changes in a person’s behavior (dependent variables) as a result of equally clearly defined procedures (independent variables; Sidman, 1960). One area in which ABA has made a significant contribution is that of challenging behavior, particularly when working with people who have a developmental disability (Iwata et al., 1996). This contribution has included the introduction and development of approaches that use empirically supported positive strategies to address challenging behavior, leading to a reduction in the reliance on punishment and other aversive strategies and to an emphasis on changes in quality of life and on social validity as important outcome measures (Carr et al., 1999). Social validity refers to the acceptability of the goals, methods, and outcomes obtained to primary and secondary consumers (Kazdin, 1977; Wolf, 1978).

Nevertheless, in keeping with the traditions of ABA, not withstanding this refreshing focus on socially valid, quality-of-life outcomes, the dependent variables in a large majority of studies involving challenging behavior have understandably included changes in the target behavior over time. The rate of challenging behavior (Ferster & Skinner, 1957) is perhaps the most commonly tracked dependent variable evident in the behavioral literature (e.g., Deitz & Repp, 1973; Deitz et al., 1978; Kahng, Iwata, Thompson, & Hanley, 2000; Luce, Delquadri, & Hall, 1980; Vollmer, 1993). Using a variety of sophisticated investigative methodologies, researchers investigate the procedure (i.e., independent variable) to determine whether it reliably produces a change in the rate of the challenging behavior (i.e., dependent variable) over time. The duration of challenging behavior (i.e., the amount of time a person engages in a challenging behavior; e.g., 4.5 hr a week) is another example of a dependent variable used to measure the effect of the independent variable on behavior over time (e.g., Jason & Liotta, 1982; Leitenberg, Agras, Thompson, & Wright, 1968; Williams, 1959).

Episodic Severity as a Dependent Variable

To date, researchers have not systematically investigated the episodic severity (ES) of behavior as a dependent variable. ES is defined here as a measure of the gravity or intensity of a behavioral incident. In this usage, the word episodic does not mean intermittent but, rather, means “with respect to an episode.” Therefore, episodic severity
would not be measured over time (e.g., 4.5 hr total duration a week, or five trips to the hospital per month for medical treatment due to self-injury) but, rather, within the cycle of a behavioral incident (e.g., an average duration of 1 hr per episode, with a range of 5 min to 2 hr per episode, or an average severity rating of 3.2 for episodes of self-injury, with a rating range of 2 to 5, using a 5-point scale of severity, with level 5 representing the need to go to the hospital for medical treatment as a result of the episode). The cycle of a behavioral incident would be circumscribed by its defined onset and offset (Johnston & Pennypacker, 1993; Sulzer-Azaroff & Mayer, 1991), or “boundaries” (Hawkins & Dobes, 1977).

ES would be measured in various ways, depending on the problem behavior. For example, the ES of a temper tantrum might be measured by the duration of the specific incident, the ES of property destruction might be measured by the cost of repair and replacement resulting from the incident, and the ES of aggression or self-injury might be measured by the scaled degree of harm or injury resulting from the incident. In fact, although not yet used for that purpose, existing scales may also be useful in measuring the ES of self-injurious behavior (Iwata, Pace, Kissel, Nau, & Farber, 1990) and aggression (Nijman et al., 1999). Other measures of ES might include the number or kind of topographies occurring during the behavioral incident, the social outcomes resulting from the incident, or any other objective measure of the gravity or intensity of an incident. These results could be reported in terms of the mean severity rating of behavioral incidents during baseline and subsequent treatment phases and the range of those severity ratings.

The distinction between the measurement of change over time, for example, in the rate or duration of behavior, and the measurement of changes in the ES of behavior is illustrated in a case study reported by Campbell and Lutzker (1993), in which the target was tantrum behavior (i.e., crying and screaming behaviors). This study reported a baseline rate of 18 episodes of the behavior per week, for an average total duration of 4.5 hr a week. By the end of Phase 2 of the study, the rate had been reduced to an average of 3.6 episodes per week, for an average total weekly duration of 55.7 min for the week, through the use of communication (functional equivalence) training. These results showed a reduction in both the rate and the duration of the behavior over time. However, although not formally investigated as a dependent variable in this study, the authors inferred from the data that there was no reduction in the ES of the behavior as measured by the average duration of an incident. During baseline, the average duration per incident was 15 min, and by the end of Phase 2, the average duration per incident was 15.5 min. The range in duration was not reported.

A focus on episodic severity has the potential to increase social validity, an important goal of positive behavioral supports (PBS; Carr et al., 1999). For example, in the Campbell and Lutzker (1993) study, the traditional focus on the rate and duration of tantrums over time would define success solely as a decrease in the level of those two variables. In contrast, measures of ES would provide additional success criteria. For example, if the weekly rate of behavior had remained unchanged but the average duration of each tantrum (ES) had been dramatically reduced, would the family have defined this as at least partial success? Would some families find it easier to deal with one tantrum a week that lasts for 30 min (low rate/high ES) and others with 30 min spread over six tantrums a week, with a 5-min average (high rate/low ES)? It seems very likely that the social validity of a behavioral support plan can be enhanced by measuring and reducing the ES of challenging behavior, in addition to improving quality of life, to reducing the rate and severity of the behavior over time, and to ensuring the durability and generalization of results.

There have been no studies within the field of applied behavior analysis in which a strategy or procedure (independent variable) has been systematically investigated for its effects on ES (dependent variable), although the importance of ES has been recognized (e.g., Albin, O’Brien, & Horner, 1995). However, ES, as a dependent variable, may be helpful in attempts to analyze and distinguish between strategies that contribute to changes in behavior within a cycle as distinct from and in addition to changes in behavior over time.

As suggested by Albin et al. (1995), those working with people who exhibit serious challenging behavior have a critical need for strategies that can quickly eliminate or minimize escalation (i.e., minimize ES) so that the important goals of long-term mitigation and improved quality of life can be safely pursued with socially valid PBS. Such strategies include ones that can be used effectively for situational management, which may be called reactive strategies. A reactive strategy may therefore be defined as one that has the purpose of bringing about the rapid or safe resolution of a behavioral incident. The term reactive strategies is preferable to the terms consequence or contingency because their effects would be measured by changes in ES, in contrast to the latter terms, whose effects are measured in terms of future behavior.

Effective reactive strategies may be needed for various reasons. These may include, but would not be limited to, the need to reduce injuries directly caused by aggressive behavior aimed at peers, staff, or others; to reduce injuries resulting from self-injurious behavior; or to reduce injuries to staff or the people they support as a result of staff’s attempts to physically manage problem behavior. There may also be the need to reduce the disruption in services or service effectiveness resulting from the ES of behavioral incidents. Furthermore, there may be a need to reduce the costs (e.g., worker’s compensation claims) and...
other risks and liabilities that may be associated with ES. The need for effective reactive strategies exists not only for high-rate behaviors but also for low-rate behaviors that have significant levels of ES, a set of behaviors for which there appears to be little, if any, research.

Without research on ES as a dependent variable, for either high-rate or low-rate behaviors, professionals who support people who manifest challenging behaviors have had to look beyond the empirical research for reactive (i.e., situational management) strategies to reduce or minimize ES. Thousands of staff are trained each year in one or more emergency or crisis management systems that have not been objectively evaluated for their effects on ES. Examples of these other approaches include The Mandt System (http://www.mandtsystem.com/), the Non-Abusive Psychological & Physical Intervention (http://www.nappi-training.com/home.html), and the Crisis Prevention Institute (http://www.crisisprevention.com/).

It is our belief that ABA can make a major contribution to this important outcome area. The exploration of ES as a dependent variable may lead to a needed evolution of an evidenced-based technology for reactive strategies (i.e., a validated technology for crisis management). However, as a prelude to this research, defining some additional terms may be useful.

**Implications**

Although specific wording and terminology varies among authors (e.g., Catania, 1992; Malott, Whaley, & Malott, 1997; Sulzer-Azaroff & Mayer, 1991), the field of ABA uses such basic terms as positive and negative reinforcement, Type I and Type II punishment, extinction, and recovery after punishment. As indicated in Sidebar 1, these basic terms are defined by their effect on the future probability of the behavior.

In contrast, when considering ES as an additional dependent variable, terms may be needed that are defined by their situational effect (i.e., by their effect on the immediate probability of the behavior or its escalation). As such, Sidebar 2 offers six new terms that might serve as a conceptually systematic context (Baer, Wolf, & Risley, 1968) for studying reactive strategies to reduce ES: positive resolution, negative resolution, Type I escalation, Type II escalation, escalation after resolution, and resolution after escalation.

Figure 1 provides summary matrices of the terms defined in Sidebars 1 and 2 and shows the parallel form between the operations that affect future behavior, in contrast to those that produce a situational effect; that is, an effect within the cycle of a behavioral incident. As indicated, the future probability of behavior may be either increased or decreased through the presentation of a stimulus or event (S), the withdrawal of a stimulus or event (S), or through the withholding of a previously available stimulus or event (O). Similarly, the immediate probability of behavior (or its escalation) may be either increased or decreased through the same three operations. These latter terms are defined by their situational effect and have obvious implications for ES. Once developed and empirically validated, resolving events can be included and escalating events can be avoided in a behavioral support plan, resulting in an immediate improvement in ES—by definition. This would also increase the social validity of PBS plans aimed primarily at long-term improvements in quality of life and reductions in the future rate and severity of challenging behavior.

Sidebar 3 illustrates each of the six defined situational effects, with concrete examples drawn from our clinical practice. Although there is no direct research with ES as an explicitly and reliably measured dependent variable, research has identified a number of strategies that might serve as resolving or escalating events. These might serve as starting points for research in this new area.

For example, Azrin (1958) found that the sudden introduction or withdrawal of a functionally unrelated stimulus could disrupt responding. Azrin concluded that this event did not have to be aversive to produce this effect but could be attributed to the phenomenon of stimulus change. Accordingly, stimulus change may be an example

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**Sidebar 1. Basic terms in applied behavior analysis and their definitions: Future effects.**

1. **Positive Reinforcement.** A process by which the contingent presentation of a stimulus or event results in an increase in the future probability of the response.

2. **Negative Reinforcement.** A process by which the contingent withdrawal of a stimulus or event results in an increase in the future probability of the response.

3. **Type I Punishment.** A process by which the contingent presentation of a stimulus or event results in a decrease in the future probability of the response.

4. **Type II Punishment.** A process by which the contingent withdrawal of a stimulus or event results in a decrease in the future probability of the response.

5. **Extinction.** A process in which the previously presented stimulus or event is withheld, resulting in a decrease in the future probability of the response.

6. **Recovery After Punishment.** A process in which the previously presented stimulus or event is withheld, resulting in an increase in the future probability of the response.
of a resolving event that could be used as part of a plan for crisis management to minimize ES (LaVigna & Donnellan, 1986).

It is well established that certain verbal consequences (e.g., reprimands) can suppress future responding (e.g., O’Leary, Kaufman, Kass, & Drabman, 1970; Van Houten, Nau, MacKenzie-Keating, Sameoto, & Colavecchia, 1982; Van Houten & Rolider, 1989). It is also very likely that the introduction of certain verbal reactions during a behavioral episode may resolve a serious behavioral event. For example, reflecting back to the person the message underlying the behavior (i.e., Active Listening; Gordon, 1970) may act to resolve an escalating situation. There is a compelling logic to the potential effectiveness of Active Listening as a resolving event, given the recognized communicative role of “aberrant” behavior (e.g., Carr & Durand, 1985; Durand, 1990). There are a number of other verbal reactions that, when presented, might also resolve a behavioral episode. These include redirection and the introduction of humorous comments. What is needed is empirical research designed to demonstrate the effects of different verbal reactions on ES.

Perhaps the most provocative and counterintuitive resolving strategies are those events that may otherwise serve as reinforcing events (LaVigna & Willis, 2003), depending on the establishing operations (Catania, 1992) or the conditions under which they are used. That is, introducing certain events such as access to desired food, activities, people, and so on, or terminating or withdrawing unwanted demands, activities, settings, and so forth, may resolve a behavioral incident, resulting in a decrease in ES. For example, distracting a child with her doll and a bottle and asking her to feed “Suzy” when the child is having a tantrum in the supermarket because she wants a lollipop, may cause the tantrum to stop (through positive resolution), as withdrawing the demand that a child turn off the television and clean his room would be likely to cause him to stop his tantrum under those circumstances (through negative resolution).

The obvious question is whether such events can be used effectively as reactive strategies without producing the countertherapeutic effect of reinforcing tantrum behavior. When ES is treated as a dependent variable (i.e., as a main effect) in its own right, increases in the future likelihood of a behavior as a function of a specific resolving event would be evidence of a negative side effect of that specific reactive strategy (Catania, 1992). This is an obvious concern. However, there are a number of strategies that might act as establishing operations that can be explored for their ability to prevent such negative side effects. Included among these are time-based schedules or manipulation of general levels of reinforcement or reinforcement density (Cautela, 1984). For example, in the former, independent, time-based delivery of an event (Poling & Normand, 1999; Tucker, Sigafoos, & Bushell, 1998) could be

Sidebar 2. Proposed terms for applied behavior analysis and their definitions: Situational effects.

1. **Positive Resolution.** A process by which the reactive presentation of a stimulus or event results in a decrease in the immediate probability of response continuation or escalation.
2. **Negative Resolution.** A process by which the reactive withdrawal of a stimulus or event results in a decrease in the immediate probability of response continuation or escalation.
3. **Type I Escalation.** A process by which the reactive presentation of a stimulus or event results in an increase in the immediate probability of response escalation.
4. **Type II Escalation.** A process by which the reactive withdrawal of a stimulus or event results in an increase in the immediate probability of response escalation.
5. **Escalation After Resolution.** A process in which the previously presented stimulus or event is withheld, resulting in an increase in the immediate probability of response escalation.
6. **Resolution After Escalation.** A process in which the previously presented stimulus or event is withheld, resulting in a decrease in the immediate probability of response escalation.

<table>
<thead>
<tr>
<th>Future Effects Matrix</th>
<th>Situational Effects Matrix</th>
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<tbody>
<tr>
<td>Positive Reinforcement</td>
<td>Positive Resolution</td>
</tr>
<tr>
<td>Punishment</td>
<td>Type I Escalation</td>
</tr>
<tr>
<td>Negative Reinforcement</td>
<td>Negative Resolution</td>
</tr>
<tr>
<td>Punishment</td>
<td>Type II Escalation</td>
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<tr>
<td>Recovery After Punishment</td>
<td>Extinction</td>
</tr>
<tr>
<td>Escalation After Resolution</td>
<td>Resolution After Resolution</td>
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Figure 1. Matrices of basic terms in applied behavior analysis.
proactively used, first, to undermine a possible contingent relationship developing between the event being used reactively and the target behavior and second, to strike a balance between deprivation and satiation, thus preventing reinforcement as a side effect. It may also be possible to avoid the negative side effect by arranging for a rich density of competing reinforcers for alternative appropriate responses (Diorio & Konarski, 1989).

Of course, it is an empirical question whether such negative side effects would develop at all in any specific situation. For example, such effects might not be seen when resolving a behavior that is a function of neurologically based impulse-control deficits or a condition such as Tourette’s syndrome. In such cases, the person may be relieved that others were able to resolve the incident. Furthermore, in such cases, it may be possible to teach the person to use such resolving events as a self-control strategy to interrupt his or her own behavior.

Finally, beyond positive and negative resolution, resolution after escalation may be the strategy of choice for reducing ES. This might be possible, given the antecedent/consequence analyses carried out as part of a functional assessment (Horner, 1994; LaVigna & Willis, 1997; O’Neill et al., 1997; Willis, LaVigna, & Donnellan, 1993). Such an assessment may identify a stimulus–response chain (Malott et al., 1997) in which an event employed as a consequence for a more innocuous topography actually escalates the response to a more serious topography (i.e., increases ES). In such a case, ES could be reduced by discontinuing the use of the planned program consequence.

For example, suppose an assessment identified “outbursts” as a target behavior representing a functional response class of topographies, including noncompliance (not performing the requested activity within the prescribed period of time), verbal refusal (saying “no”), and aggression (hitting others). Suppose further that a functional assessment identified a chained stimulus–response pattern of escalation in which, when the person is “verbally reprimanded” for noncompliance, his behavior escalates to verbal refusal, and when he is then “physically prompted” (i.e., required) to comply, his behavior escalates to aggression. Given these conditions, the support plan may specifically include, among other things, the recommendation that verbal reprimands and physical prompting not be used under these circumstances. This may lead to an immediate reduction in ES. That is, the proportion of episodes of outbursts that escalates to aggression may be reduced. In addition, the plan may simultaneously call for the development of a powerful token reinforcement system to increase compliance and decrease the rate of outbursts, and for the teaching of coping and tolerance of nonpreferred tasks when the token reinforcement system is ultimately phased out.

To say, however, that the above example represents a reduction in ES depends on how we define our target behavior. In this specific example, the target of outburst behavior was defined as described above, with aggression representing the most severe topography within the class. Given this definition, the withholding of verbal reprimands and physical prompting would represent a reactive strategy involving resolution after escalation. If in such a situation we defined our target behavior as “aggression,” the withholding of verbal reprimands and physical prompting, even in response to the (now) precursor behaviors of noncompliance and verbal refusal, would represent an antecedent control strategy reducing the rate of aggression, rather than a reactive strategy reducing the ES of outburst behavior.

Sidebar 3. Examples illustrating how each of the six situational effects affects episodic severity.

**Positive Resolution:** In a school setting, when a 7-year-old girl would run off of the school grounds, her name was called and she was coaxed back by holding up a “Mars Bar,” thereby reducing ES (see Note).

**Negative Resolution:** In a serious case of “life-threatening” self-injury and aggression, rapid and safe resolution was possible and the need for medical attention was avoided when staff realized that if they left the area at the start of episode, the client would cease exhibiting the target behavior, thereby reducing ES (see Note).

**Type I Escalation:** Our functional assessments have revealed that physical “prompts” to force performance, as is sometimes done in compliance training programs, can escalate behavior to crisis levels, thereby increasing ES.

**Type II Escalation:** Our functional assessments have revealed that physically removing a child from a classroom as part of a “time-out” procedure for disruptive classroom behavior, can escalate behavior to crisis levels, thereby increasing ES.

**Escalation After Resolution:** Our functional assessments have revealed that initiating an escape extinction procedure, for example, for self-injury, can result in increases in ES.

**Resolution After Escalation:** We have recommended discontinuing the use of physical prompts when they have been associated, through a functional assessment, with an escalation in behavior, resulting in decreases in ES (see Note).

Note. The constructional, nonlinear roots of PBS, including the concepts of alternative sets (Goldiamond, 1974, 1975) can be tapped to prevent the reinforcement of the problem behavior (i.e., the potential countertherapeutic effects of these strategies).
Even with reactive strategies, situational effects may be more usefully understood in terms of antecedent control rather than in terms of consequences. That is, when the situational effect is resolution, the effect occurs either through the introduction of those antecedents that set the occasion for competing behavior (as might occur when a mother hands her child his or her security blanket and finds that it evokes behavior [such as cooing, gurgling, and thumb in mouth] incompatible with the child’s tantrum behaviors that were occurring because of being denied a lollipop) or removes those that set the occasion for the target behavior. When the situational effect is escalation, the effect occurs either through the introduction of those antecedents that set the occasion for the target behavior or removes those that set the occasion for a competing behavior.

More generally, Type I and Type II punishment, as aversive events, may be establishing operations for the higher likelihood of aggression (Malott et al., 1997; Pierce & Epling, 1995) and other escape behaviors (Vargas, 1977). They, therefore, may represent Type I and Type II escalating events, under certain conditions, when aggression and other escape behaviors are indicators of ES. Similarly, “extinction bursts” (Lerman & Iwata, 1995; Lerman, Iwata, & Wallace, 1999) may represent an example of escalation after resolution. The extent to which escalation occurs in providing behavioral support is not clear, as ES has not been explicitly, objectively, or reliably reported in applied research. If such events are shown or known to be escalating events, it may be important to avoid them in situations in which ES is a concern.

In such situations, the suppression, reduction, or elimination of future target behavior might better be sought through positive and proactive strategies, such as antecedent control (e.g., Luiselli & Cameron, 1999), differential schedules of reinforcement (LaVigna & Donnellan, 1986), time-based schedules (Poling & Normand, 1999; Tucker et al., 1998), communication training (e.g., Carr & Durand, 1985; Durand, 1990), coping and tolerance training and other positive programming, and ecological and focused support strategies (i.e., proactive strategies; LaVigna, Willis, & Donnellan, 1989). Reactive strategies can then be reserved solely for the important role of minimizing ES.

Of course, although escalation may be considered as undesirable in the area of challenging behavior, this would not be true in all situations. For example, in the shaping of speech in young children with autism, extinction is explicitly used as a therapeutic strategy to escalate behavior (Lovas, 1981). This would be an example of escalation after resolution, and it is done to produce behavioral variability and more options for shaping behavior toward speech.

Furthermore, it is important to make the explicit point that in the area of challenging behavior, the concept of ES has implications for more than the development of reactive strategies for crisis management. Certain proactive strategies may also decrease (or increase) ES. In a rare case study, Neufeld and Fantuzzo (1987) reported a reduction in ES. In that study, the proactive use of a protective helmet was reported to reduce the ES of self-injurious behavior. Data analysis was carried out based on a retrospective review of mean severity ratings of self-injurious behavior incidents; however, observational reliability was not reported. In a multiple-baseline study, the severity of resistance to dental treatment was reliably measured by session, rather than by behavioral incident (Maguire, Lange, Schling, & Grow, 1996). The dependent variable of session severity (vs. episodic severity) was reduced through the proactive use of rehearsal and positive reinforcement. The results of this study indicate that ES could be reliably measured.

In future research, it would be interesting to explore other proactive strategies to empirically determine, for example, whether the proactive use of time-based schedules (Poling & Normand, 1999; Tucker et al., 1998) would reduce ES. That is, for example, tantrums might have reduced ES if they occurred in settings in which a high density of reinforcement had been arranged, as opposed to those that occurred in settings with a relatively lower density of reinforcement, independent of the reactive strategies employed.

Whether or not proactive or reactive strategies are included in a plan for the specific purpose of reducing ES, it may still be important to produce pre- and postintervention ES data. This might allow one to make statements regarding changes in ES in comparison with trend lines that portray changes in critical skills learned, reductions in the rate and severity of behavior over time, changes in community presence and other quality of life changes, and so forth. Different changes and trends may be better received by clients and families than others, providing a basis for improving the social validity of PBS. At the very least, the behavior analyst would have a responsibility not to do anything to increase ES in cases in which increases may be undesirable.

Conclusion

This discussion has presented the concept of ES as an additional dependent variable for study in the field of behavior analysis as it applies to challenging behavior. It has introduced a conceptual framework for understanding ES and an agenda for future research. This agenda includes, among other things, developing methods for obtaining reliable and valid measures of ES, developing and validating proactive and reactive strategies for reducing ES, and developing and validating potential establishing operations and other procedures for preventing the negative side effects that may be associated with some strategies. Perhaps the greatest challenge, however, may be the development
and validation of strategies to establish the social validity of reactive strategies based on the concept and procedures of resolution. This is because they might appear to fly in the face of the understandable practice of avoiding the reinforcement of challenging behavior. ABA, however, is well equipped to meet the challenge of developing reactive strategies that reduce and minimize ES without producing the negative side effect of reinforcement.

We also believe that this research agenda has the potential to make a contribution to the further development of PBS. This opportunity goes beyond developing effective and positive proactive strategies for purposes of improving quality of life and reducing the rate and other measures of problem behavior over time. It also includes developing effective and positive reactive and proactive strategies for reducing episodic validity, thereby enhancing the social validity of PBS.

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REFERENCES


