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Mediator Analysis

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Introduction

As Clinical Behavior Analysts, we are called on to make recommendations to parents regarding their children, to teachers regarding their students, and to staff regarding their consumers/clients. For example, we ask parents to record on a calendar each time that their child has a tantrum and we ask that they reinforce “consistently” each time that the child is cooperative or does not have a tantrum. We ask the teacher to allow the child to take a break when he presents a “red card” and to deliver a token (i.e., happy face on a sheet of paper) at random intervals throughout the day when the child is “on task.” (The teacher has 13 other students in her class.) We ask group home staff to use “active listening” when one of their charges has a tantrum and breaks property in the home. We make these recommendations and frequently become frustrated when they are not implemented as we suggested. We may describe the parent who is inconsistent in his/her data collection and does not reinforce as suggested as “noncompliant” and we may suggest that the family does not need or at least not want the help.

We frequently make recommendations assuming that they can be carried out; that those to whom we have given the recommendations believe in what we have recommended,

want to participate, are motivated to participate, and have the physical/technical skills to do what we have suggested. Traditionally, little attention has been given to these issues in

the field of Behavior Analysis. **These are Mediator Issues.**

Mediators are those individuals who we would expect to carry out a support plan (e.g., parents, teachers, staff), to carry out our recommendations (see Tharp & Wetzel, 1969). In order for a support plan to be successful, the people who are 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).

In the Mediator Analysis, we attempt to answer several questions, including the following:

- Do the mediators wish to participate in implementing the support plan?
- Are the mediators likely to cooperate with our recommendations?

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Editors' Note...

In this issue of *Positive Practices* we continue our presentation of issues related to Behavioral Assessment; namely, Mediator Analysis. This is an often overlooked, but extremely important, component of an assessment. We are sure that many of you have experienced a situation where after spending many hours conducting a behavioral assessment, and designing a support plan, the people who are supposed to implement the plan just don't do it, or can't. In this article we identify some of the mediator issues that must be taken into consideration when designing a support plan. Remember, not everyone can do what we recommend and not everyone wants to. It is important to identify these counter-therapeutic issues up front through a Mediator Analysis.

We also want to take this opportunity to announce a new column that will be added to future issues — "The Creative Corner." The purpose of this column is to take advantage of your CREATIVITY. It has been our experience many good treatment ideas are never known outside of the individual support plan for which they were designed. What a waste of creative efforts. Wouldn't it be nice if there were a place where professionals could share their ideas, their strategies, their innovative thoughts with other professionals. Wouldn't it be nice if we didn't always have to REINVENT THE WHEEL. In this endeavor, we invite you to submit your ideas. Describe unusual and exciting reward programs, describe how crises were averted through creative reactions, describe new and novel teaching strategies, describe how behaviors changed as a result of simple, non-intrusive ecological changes, etc. When you submit your ideas, give us a short description of the person (e.g., age, sex, disability, level of learning difficulty) and the challenging behavior(s). We will contact you if we select your ideas for publication. Your ideas can be submitted on our web site at <http://www.iaba.com>, or you can send them to our Los Angeles address. WE HOPE TO HEAR FROM YOU.

We also want to announce that in the very near future, psychologists will be able to earn APA approved CE credit on-line for reading *Positive Practices* and our other resources and for attending seminars. More information will follow on this topic.

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An Application of Crisis Services Within the Multielement Approach: A Community Behavioral Support and Crisis Response Demonstration Project

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Editors' Note: Since the mid-1980's there has been an international effort to move people out of large state and national institutions into local communities. This effort burgeoned in the 1990's in the United States as many state institutions were being closed. Unfortunately, many people returned after unsuccessful placements, while others were placed in state institutions for the first time. A vast majority of the placements in state institutions were because of behavioral challenges that ostensibly could not be managed in the community for lack of resources. In this article, Joan Oslund, Wayne Larson, Cynthia Rudolph and Charlie Lakin report on a two-year demonstration project in Minnesota designed to reduce the number of people who return to state institutions from the community or enter for the first time. The results, although preliminary, are exciting in that they show a positive impact and demonstrate a further application of the Multielement Model.

Introduction

The impact of challenging behavior on the community service options and social opportunities of persons with developmental disabilities has been well documented. Individuals exhibiting challenging behavior are at greater risk of being “demitted” from their community residences (Borthwick, 1988; Bruininks, Hill & Morreau, 1988), and often face more obstacles to acceptance by community service providers (Hill, Lakin et al., 1989; Scheerenberger, 1981) than their counterparts without behavioral challenges. They are also more likely to be admitted or readmitted to large public institutions (Hill & Bruininks, 1984; Intagliata & Willer, 1982). The presence of challenging behavior with persons with developmental disabilities has been shown to limit opportunities for social interactions and relationships (Anderson, Lakin, Hill & Chen, 1992). In addition, challenging behavior may exclude many persons with developmental disabilities from the positive advantages of community living, that have been greatly advanced by service changes in recent years.

A number of community behavioral support and crisis response programs have been created in recent years to address the needs of individuals with developmental disabilities who display challenging behavior (Beasley, Kroll, & Sovner, 1992; Colond & Weiseler, 1995; Davidson et al., 1994; Donnellan, LaVigna, Zambito, & Thvedt, 1985). These authors have pinpointed various features of their successful programs.

Given the high comorbidity of developmental disabilities and psychiatric disorders and the significant potential for the misdiagnosis of psychiatric problems (Marcos, Gil & Vasquez, 1986; Menolascino, 1989; Reiss, 1990; Woodward, 1993), a key ingredient in existing models is the inclusion of mental health professionals. Models for the provision of crisis services stress interdisciplinary approaches, including the incorporation of psychiatric expertise into the treatment teams (Beasley et al., 1992) and linkages with the mental health system at both primary and tertiary levels (Davidson et al., 1995).

A second important aspect of crisis service models is an emphasis on prevention. Colond and Weiseler (1995) document the effectiveness of providing such services within the context of individuals' existing community residences. Davidson et al. (1995) stress the early identification of individuals who may be at risk of needing crisis services and training for those individuals, their families, and service providers. Preventative approaches also emphasize the importance of developing the crisis management and identification competencies of community service providers and families (Beasley et al., 1992; Davidson et al., 1995).

Some existing crisis service models provide “less restrictive” short-term residential alternatives to psychiatric hospitalization and, in in-

stances in which such hospitalization is necessary, the enhancement of hospitalization through coordinated efforts. For example, Davidson et al. (1995), describe a “continuum” of residential options, ranging from respite and group homes specializing in behavioral interventions, to collaborative work with inpatient psychiatric units and intensive post-discharge follow-up. Beasley et al. (1992) recommend short-term (i.e., not more than 30 days) mental health respite

...these individuals were admitted for short-term stays in response to behavioral crises...

care in community-type settings and, when necessary, psychiatric hospitalization conducted with the supervision of the specially-trained crisis team.

This paper discusses the development of a two year demonstration project in Minnesota. Like a number of other states, Minnesota is rapidly closing state institutions for persons with developmental disabilities. In just five years between June 1990 and June 1995, the state institution population decreased from 1,337 to 524 people. Despite the rapid depopulation of Minnesota’s state institutions, during the same period an average of 122 people were admitted each year back to state institutions. The vast majority of these individuals (77% in 1994) were admitted for short-term stays (less than 90 days) in response to behavioral crises and other emergencies. It is planned to provide 30 - 50 beds in a central state-operated program - the Minnesota Extended Treatment Option (METO). Building of the small cottages will begin in the summer of 1997.

Method

Program Description

In 1992, the Minnesota State Legislature responded to a request from various state, county, and community agencies by authorizing funding for a single community crisis intervention and behavioral support programs for persons with developmental disabilities (DD). This project, the “Special Services Program” (SSP), is located within an ICF/MR (Intermediate Care Facility for [persons who are] Mentally Retarded) in a suburb of Minneapolis to serve five counties in the western Minneapolis metropolitan area. Two goals were established for the SSP. The first was to prevent out-of-home placements due to behavioral episodes or, when necessary, to provide a short-term residential community alternative to psychiatric and state regional center admission. The second goal was to keep the at-risk individuals in their homes and communities at equal or lower costs than would have been expended for more restrictive residential treatment.

Program Characteristics

The SSP provides two types of services: outreach in the individuals’ home, workplace, school, or other community settings; and short-term (i.e. 90 days or less) inpatient treatment in a specialized unit. Both services involve a interdisciplinary team focusing on nonaversive behavioral interventions guided by a functional analysis of challenging behavior. The teams include a program director with extensive experience in mental health, two behavior analysts, a psychiatric nurse, an intake worker, and (on the unit) experienced direct care staff. It

is further supported by on-going consultation with a board-certified psychiatrist and licensed psychologist. Based on this model, the SSP team is able to assess a range of environmental, medical, psychiatric, psychological, and communicative factors that may contribute to the individual’s at-risk status.

Outreach services include functionally analyzing the challenging behavior for which the client is referred, technical assistance in devising appropriate methods of intervention, and careprovider training. The residential unit provides intensive support and intervention for clients whose behavioral challenges seriously jeopardize their current residential or other service participation. Consultation is provided by the SSP staff on long-term planning of more appropriate accommodations and supports to permit the individual to return home or move to another appropriate residential setting. The short-term unit is staffed 24 hours per day with a minimum staff-to-client ratio of two-to-four during waking hours. The unit can accommodate four clients at a time. To the extent feasible, clients maintain their school or day activity programs while on the unit.

Referrals

Referrals are made by county case managers. Priority for services is given to individuals from the SSP’s five-county service area. When possible, outreach services (in-home) are promoted as the first option. As advised by other providers of crisis prevention and intervention services (e.g. Beasley et al., 1992; Davidson et al., 1995), the SSP’s home facility receives direct funding so that there is no fee for outreach services and individuals can access these services regardless of their insurance coverage or ability to pay. Crisis unit clients must have Medicaid or other financial

resources to defray the cost of these services.

Provision of Services

Outreach and crisis unit services are provided in three phases: 1) assessment; 2) intervention/training (including the development of a Crisis Prevention/Intervention Plan); and 3) follow-up. The foundation of the format for the assessment and intervention process is based on instruments and format designed by the Institute for Applied Behavior Analysis (Willis, LaVigna, & Donnellan, 1993; LaVigna & Donnellan, 1986; LaVigna & Willis, 1995).

Assessment. Assessment is designed to be brief, but intense, so that preliminary recommendations can be developed and presented to Interdisciplinary Teams (IDT) within one week of service commencement. Assessments are conducted by a behavior analyst and a psychiatric nurse. The assessment includes individual and group interviews with family members and service providers, a records review, and direct observation of clients in their home and day program. The team uses both verbal and written formats for gathering information relevant to each individual's situation. Topics covered include social interaction and communication, medical, mental health, personal preferences, reinforcement histories, and a functional analyses of the target behavior(s). The team draws on various interview/assessment tools, including the Motivation Assessment Scale (Durand, 1988), the Functional Analysis Screening Tool (Iwata, 1995), the Problem Behavior Inventory (Willis & LaVigna, 1989), and functional analysis methods developed by O'Neill, Horner, Albin, Storey, and Sprague (1990).

Intervention/Training. Recommendations for intervention and training are then presented to the client's

IDT. These include the following: a) proactive strategies; b) environmental or ecological modifications; c) reactive/emergency strategies; d) staff/careprovider training; e) data collection; and f) follow-up.

The subsequent intervention and training strategies used are determined by the input of individuals' IDT. Intervention strategies concentrate on the development of alternative social skills, communication competencies, and environmental modifications which may alleviate particular behavioral situations. Often additional recommendations are received from the consulting psychiatrist and psychologist. Referrals are made to other medical specialists or to communication specialists.

Reactive strategies are also devised to nonaversively intervene in the occurrence of challenging behavior. Individualized crisis prevention plans are developed to assist families and service providers.

In accordance with Minnesota regulations, procedures such as seclusion and faradic shock are prohibited. Certain other procedures (e.g. exclusionary time out, room time out, manual restraint, mechanical restraint, restitutive overcorrection, etc.) are also limited and strictly controlled by Minnesota regulations. The SSP teams generally do not recommend these strategies be included in a Crisis Intervention/Support Plan. However, some emergency use of controlled procedures (e.g. manual restraint to prevent a person from harming himself or others) may be indicated as part of a Crisis Inter-

vention/Support Plan.

Full results are likely to require multielement treatment plans, the various components of which, in combination address the full range of outcome requirements (LaVigna, Willis & Donnellan, 1989).

On-going consultation regarding the implementation of specific interventions is provided. This may entail verbal and written instructions, modeling, and role-playing exercise. When possible, the SSP either directly or via other specialists in the community provides educational materials and training on specialized issues (e.g. communication strategies, autism, sensory integration, particular psychiatric diagnosis, etc.).

Follow-up. The SSP team follows clients for one year from service commencement. Contact is made on a weekly or bi-weekly basis depending on the needs of individuals and the wishes of their IDTs. Throughout the remainder of the year the SSP maintains quarterly telephone contact with service providers, families and county case managers. They may also make

The foundation of the format for the assessment and intervention process is based on instruments and format designed by the Institute for Applied Behavior Analysis.

in-home visits and attend IDT meetings. Follow-up enables the SSP to keep informed of the client's adjustment following discharge and offer further assistance.

Between April of 1993 and December of 1994, the Special Services Program provided services to 76 clients. An additional 24 individuals were denied services during that pe-

riod either because the SSP crisis unit was full, the wait for services was considered to be too long by their IDTs, or they were not from the five-county area. These individuals served as the comparison group when calculating the estimated service outcomes and expenditures.

To compile the characteristics and service histories of SSP clients, a detailed record review was conducted using information gathered at intake. Additionally, follow-up data on service changes and other concerns was collected via quarterly phone contact with case managers and primary careproviders of persons served in 1993 for one year following completion of SSP services. Analysis of the cost effectiveness of the SSP was performed through an estimation of service expenditures in the absence of the program. Case managers of the 76 clients identified what would have most likely happened to each individual had the SSP not been available.

This was based on their experience and knowledge of the service options available prior to the development of the SSP. Estimated cost of these outcomes were computed using current average costs from the payment files of the Minnesota Department of Human Services. These alternative scenario cost estimates were then compared to the prorated development and operational costs of the SSP.

Results

Participants

Diagnostic Characteristics. The most common behavioral concerns at the time of initial referral included: physical aggression toward other persons (71%); verbal aggression (50%); property destruction (26%); and self-injurious behavior (21%); with non-compliance, running away, and theft each being mentioned for at least 10% of individuals. More than three-fourths

(82%) of all clients had a psychiatric diagnosis, including most frequently schizophrenia or other psychotic disorders, personality disorders, affective disorders, and impulse control disorders. Figure 1 displays these characteristics graphically.

Demographic Characteristics. The ethnic representation corresponded roughly to the ethnic composition of the Twin Cities metropolitan area. Clients ranged in age from eight to 67 years, with an average of 29.6 years. A quarter of clients were less than 17 years old. Sixty seven percent of the clients served were male.

Service History. Seventy five percent of the 16 clients served in the crisis unit were initially placed out of their family homes by the age of 16, as compared with 54% of outreach clients.

Outcomes

Table 1 compares residential situations of those clients referred in 1993 to their situation at the end of 1994.

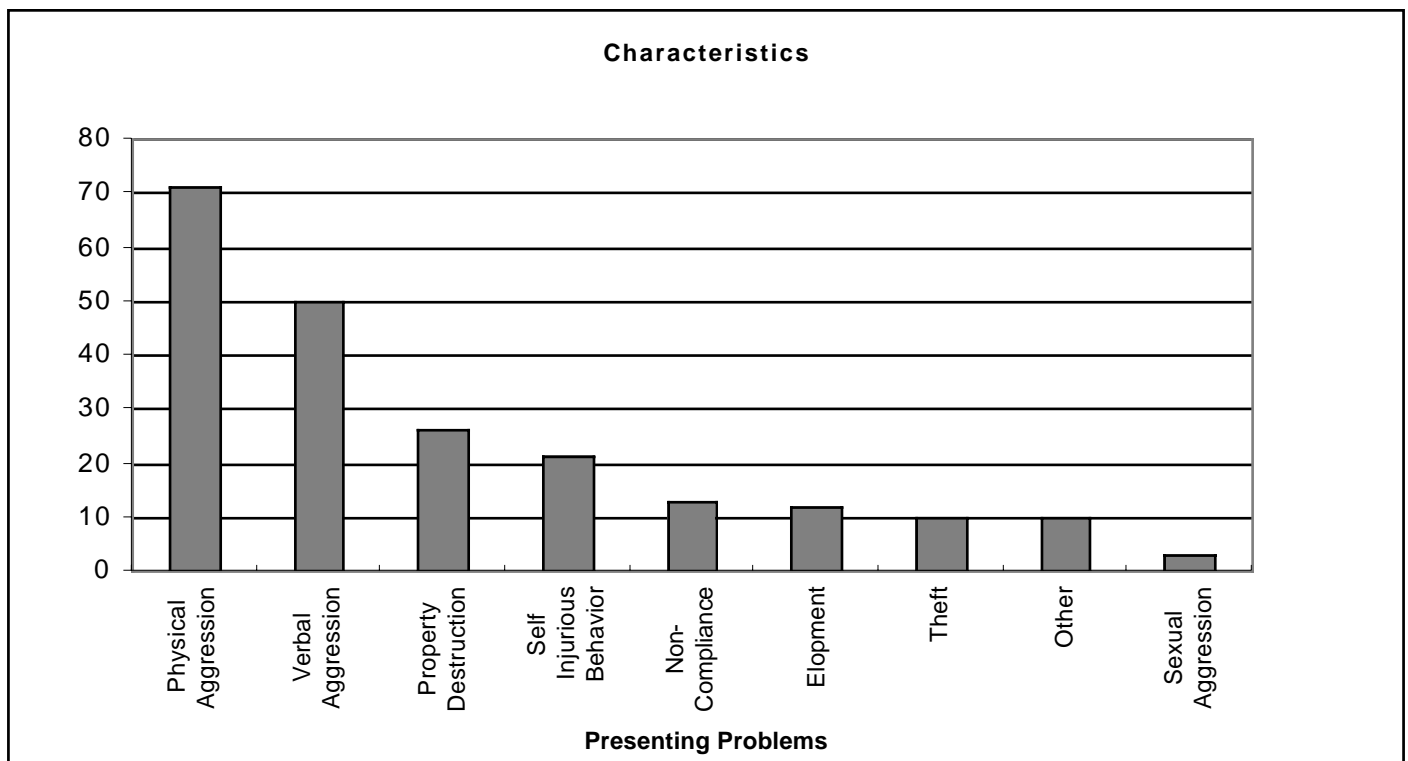


Figure 1. Behavioral and psychiatric problems at time of initial referral for SSP services (N=76). May be more than one presenting problem per service recipient

Fifty eight percent of the clients served through outreach services remained in the same residential setting throughout 1994 as they had been at the time of initial referral in 1993. This compares with 25% of crisis unit users. Sixty percent of the individuals who were unable to access SSP services did not change residential settings. For five of these six individuals, additional in-home supports were secured.

As can be seen in Table 1, only one of the 24 individuals who received SSP services in 1993 was placed in a state regional center in the following year, whereas four of the ten individuals unable to access services were placed (three on a long-term basis and one on an interim basis).

Satisfaction - Careproviders. Satisfaction was measured using a five-point scale. Post-service telephone interviews were conducted with 32 primary careproviders of persons receiving SSP services in 1994. Fifty-six percent rated their overall satisfaction as “very high” and 44% rated it “high”. Four-fifths of careproviders gave staff “very high” satisfaction ratings. Careproviders frequently volunteered being impressed with the

“nonthreatening” and “non-judgmental” approach of the staff.

Different concerns were noted by careproviders. Four (20%) of the careproviders interviewed thought SSP staff would have developed a more “realistic” picture of specific behavioral issues with additional and longer visits. The concern by 25% of careproviders of persons placed in the crisis unit was that day activities were insufficient.

Satisfaction - Case Managers. Of the 46 case managers responding, 63% rated their satisfaction with service outcomes as “very high” and 37% rated it “high”.

The primary dissatisfactions of the case managers revolved around the time lapse between referral and initiation of service. The 90-day placement limit for crisis unit services was too short to develop new residential programs for people who were unable to return to their pre-SSP settings.

Cost Effectiveness. Estimates of the cost effectiveness of the project were based on projections of the most likely service disposition for each SSP client in the absence of the program. These projected outcomes were ob-

tained through interviews with each client’s case manager. Dispositions were stated in terms of residential and other support services and their probable length (e.g. increased or decreased hours of case management, psychological services, etc.). Expenditures were estimated based upon average costs for those services in the metropolitan area.

They were limited to a 90 day period from referral because of lower reliability of longer projections.

Case managers projected that 27

Cost Effective	
Total Estimated Service Expenditures in Absence of SSP Operation in 1994 ...	\$722,320
Total Expenditure for Developing and Operating SSP and its Physical Space in 1994	\$435,148
Total Estimated Reduction in Total Expenditures	\$287,172

Table 2. Comparison of Expenditures for Developing and Operating SSP and Physical Space with Estimated Expenditures in its Absence in 1994

	Outcomes					
	Same Residence	New Community Residence with Less Structure	New Community Residence with Similar Structure	New Community Residence with More Structure	From Family Home to Community Residence	State Institution
Outreach Service Recipients (N=12)	7	0	2	2	0	1
Crisis Unit Service Recipients (N=12)	3	3	1	0	5	0
Service Referrals not receiving SSP Services (N=10)	6	0	0	0	0	4

Table 1. Residential Situation at End of 1994 As Compared to Residential Situation at Time of Initial Referral for SSP Services in 1993

of 54 individuals completing SSP services in 1994 would have been placed on a short-term basis (90 days or less) in a state regional center. The total costs projected for persons who were served in the crisis unit had the unit not been available were \$414,619 or \$20,731 per person.

Expenditures of \$307,703 or \$9,050 per person were projected for persons served off-campus had those services not been available. Therefore, the average projected alternative expenditures for all SSP participants were \$13,376 per person.

In 1994, total expenditures for SSP operations were \$435,148, including \$26,553 for 1,308 resident days on the crisis unit (89.6% of full capacity). The net projected expenditures for SSP participants in the absence of the program were \$722,320. Based on projected expenditures for alternative services and established costs of development and operation of the SSP in 1994, costs for SSP clients were \$287,172 less than the costs of services that would have been used in the absence of the SSP (i.e. \$722,320 - \$435,148; see Table 2).

Validation. While it seemed clear that there were no better sources of projected outcomes for individuals in the absence of the SSP than those individuals' case managers, it also seemed important to validate their projections. This was done through follow-up on 14 individuals who were unable to access SSP services in 1994. Because these unserved individuals were similar to those clients served in the SSP, their actual experiences were used to test the accuracy of the case managers' projections of what would have happened to individuals actually served by the SSP had the unit not been available. Analysis of actual outcomes for these 14 individuals demonstrated that one half actually were admitted on a short-term basis to a state regional center, while one was

placed in a psychiatric hospital.

These expenditures yielded a per person average estimated expenditure of \$13,273 (in the absence of the SSP). This compares with the average alternative expenditure of \$13,376 for SSP participants. These similar amounts provide strong support for the assumptions of the case managers' projections of likely service scenarios and expenditures in the absence of the SSP.

Discussion

Throughout the course of providing crisis services the extensive needs of individuals and the gaps in the present service system have become obvious. While the multielement approach to assessment and intervention has been a comprehensive and effective means of producing change, it is clear that much time is necessary to accomplish the task with limited resources. As illustrated by the satisfaction survey results the clients and their careproviders expect high quality supports and services from the system.

Although the SSP is limited by its resources, the project demonstrates the need for community-based support before a deterioration in behavior lead to more costly and restrictive services.

Also of concern is the current system's inability to provide adequate supports to prevent repeated residential moves. While crisis unit services were highly thought of, it is not acceptable for temporary placements to be extended or repeated. In June 1995, the Legislature authorized a proposal to further develop programs making behavioral supports and crisis response services available throughout Minnesota. These programs began operation later in 1996. Implementation of this statewide network of behavioral support and crisis response

will help to assure a permanent place in the community for all Minnesotans with developmental disabilities. In this regard, a seven-county metropolitan area coordination effort to further expedite and develop crisis services is in process.

We encourage other providers to develop service outcome and cost-effectiveness studies so we can more fully understand the dynamics of crisis prevention and intervention services.

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Continued from page 1

- Are the beliefs or philosophies of the mediators consistent with those that form the foundation of our recommendations?
- Do the mediators have the physical and staffing resources to carry out the support plan as recommended?
- Are there barriers (e.g., emotional, social, financial, work-related) that might preclude the mediator from carrying out our recommendations?
- Do the mediators have the training and knowledge necessary to implement the recommendations; and if not, how much and what type of training will they need?
- What additional resources and services are necessary for the plan to be carried out successfully.

Answers to these questions may not be straight forward. While some might be answered through very direct and specific questions, the Mediator Analysis involves reaching conclusions as to whether there may be one or more mediator characteristics that may act as barriers to the consistent implementations of the recommended support plan. These conclusions may be based on information derived from a wide variety of sources reported elsewhere in the behavior assessment and functional analysis or may be based on information specifically gathered and reported as part of the mediator analysis itself. For example, a mediator is unlikely to say "I am unmotivated and I won't cooperate," although this does happen on occasion. We might infer the mediator's motivation, however, from how the person presents themselves, the "excuses" the person gives for not being available, etc. A mediator may be unwilling to say "I am overwhelmed." It might only be evident from the person's emotional expres-

sion during an interview (e.g., tears), or in comments such as "Sometimes I just want to run away and not come back." "I wish I was never born."

Most parents and teachers don't come right out and say (some do) "I don't believe in this positive stuff, I believe in firm discipline." But we may get a good understanding of potential philosophical conflicts when we begin addressing child-rearing methods (which we might describe as part of the person's family background) and/or behavior management strategies (which we might describe as part of the consequence analysis). For example, when talking to parents we will ask about how they might manage their child's behavior. We will even ask about hypothetical behavior problems. At the end of our questions, we may come away with the impression that the parent(s) rely heavily on aversive methods. In some cases, the parent might say things like "I've tried those (positive strategies) but they didn't work. The only thing that seems to work is taking away his _____."

As we talk to staff and teachers, they may not be willing to come right out and say things like "He is disgusting." Rather, this might be inferred from their expressions. They may say things like "It is hard to work with him when he _____."

Information for the Mediator Analysis is gathered in a variety of ways, including direct observation, direct interviews, attitudes of those being interviewed, written records, expressions, statements from the consumer, etc. The Behavior Analyst must be sensitive throughout the behavioral assessment to potential barriers; actions, attitudes, philosophies, resources, etc., that might interfere with the implementation of recommendations. In the following pages, we present different points of focus for a Mediator Analysis that might help

answer important mediator questions.

Some people feel that they can't honestly and fully report the results of their mediator analysis because it will insult the mediators and/or create a negative reaction that itself can be a barrier to implementation. We have

Some of the following illustrative examples describe parents as mediators and some describe staff as mediators. You may want to keep in mind that these issues have their parallel counterparts. That is, if the example is referring to parents as a mediator,

you should consider how the issue would manifest itself with staff. Conversely, if the example is referring to staff, you should consider how that same issue might manifest itself with parents.

We have learned that the results of a mediator analysis should be provided descriptively rather than judgementally...

learned that the results of a mediator analysis should be provided descriptively rather than judgementally and, where ever possible, described from the mediators' point of view. For example, in carrying out an assessment in a group home setting, we became aware that the staff simply did not want to work with the focus person any more. To report this as a negative judgment of staff's professionalism would not have been productive. Rather, we reported this finding from their point of view, i.e., that they were feeling that the other residents of the home had not been getting a fair share of their time and therefore staff felt that they could not fairly give the focus person the attention he would need without further depriving the other residents. Accordingly we recommended a time-limited, intensive support team to implement the early stages of the plan in order to give the primary staff some respite. As a result, the person's placement was saved, primary staff recouped and, at their request, eventually took over responsibility, and the person's challenging behavior was resolved along with a major improvement in his quality of life.

Some Focus Points for a Mediator Analysis

A. Motivation. The Mediator Analysis begins with information about the referral; "Who made the referral?" Research in rather clear in this area, people/families who are self-referred or referred by individual professionals, rather than by an agency, show better outcomes (Gaines & Stedman, 1981; McMahon, Forehand, Griest, & Wells, 1981). So, we might ask "Why are you here?" "What brought you to need this assessment?" "How did you come to be referred to _____?" Lack of motivation for the assessment and subsequent treatment may be reflected in answers such as "My social worker said I should come." "The court said I won't get my kids back if I don't take a class." "I really don't have a problem, but the school said I needed to get some help for my child."

Answers such as these may reflect poor motivation. More importantly, the lack of motivation

may be reflected in poor outcome, but also wasted cost and professional time (e.g., missed appointments, late appointments, incomplete assignments).

B. Expectations Surrounding Behavioral Services. The expectations that people have about the nature of behavioral services may be counter-therapeutic. Many people view treatment as taking the child or adult to the counselor or psychiatrist to be "fixed" or "cured." Behavioral services (e.g., parent training), on the other hand, requires that the participants or mediators take an "active role." Participation may include observation, mastery of educational materials, helping a team develop and revise support plans, attending weekly/monthly training or team meetings, summarizing data, frequent telephone contacts, etc. The demands for active participation in the process of providing behavioral services may determine whether people agree to participate or not; and may have an impact on who persists and who drops out (Kazdin, 1985).

In the Mediator Analysis it is important to determine the expectations the mediators have regarding behavioral services or training. There is every reason to believe that if they begin with the **WRONG EXPECTATIONS** the outcomes will not be positive. For example, Baekeland and Lundwall (1975) identified a number of factors that were associated with participants dropping out. Lower socioeconomic status was one of these factors. They suggested that this might reflect a **conflict** between the client's expectations and the values and expectations of the specialist.

One way of resolving the problem of people dropping out be-

cause of unrealized or conflicting expectations is to lay out the expectations for them so that they can make decisions about whether they want to or can participate effectively with the recommendations. This is frequently done in the form of an Informed Consent and Service Agreement in which the expectations are listed in writing and the mediator is asked to indicate their agreement or disagreement to each item. Prior to the initiation of behavioral services, there may be negotiation around the expectations. Agreement should be reached prior to service initiation. If agreement cannot be achieved, then alternative resources or services may be suggested.

C. Parent and Family Risk Factors.

Not every parent or family may be candidates for parent training. The literature is replete with research describing Risk Factors associated with poor outcomes. Some of the risk factors described in the parent-training literature (Patterson, 1974; Reisinger, Frangia & Hoffman, 1976; Strain, Young, & Horowitz, 1981) include:

- families with father absent
 - lower socioeconomic status
 - marital discord
 - greater parent psychopathology
- Wahler and colleagues (Wahler, Leske, & Rogers, 1979; Wahler, 1980) have conducted extensive research related to factors that might influence the outcome of parent training and behavioral services. The High-Risk factors they identified included:
- families with the father absent
 - lower socioeconomic status
 - poor education
 - live in crowded and high-crime area
 - living at the poverty level

Their research showed that high-risk families were more likely

to discontinue behavioral services, and if they continued, they required 50 percent more training and consultation than other families before they achieved satisfactory performance. More importantly, their data failed to show significant gains as a result of parent training on the part of high-risk families.

In our work with families, the two factors that have sometimes appeared to impede progress have been those families in which there is only **one parent or where there is marital discord**. These factors, therefore, are risks that should be identified and addressed as part of the mediator analysis.

Single Parenting. Parenting is difficult enough when there are two parents. But consider a family in which there are two or three children, one child with serious behavioral challenges, and only one parent. The stressors of parenting are compounded logarithmically. When we do an assessment we must attempt to determine whether the parent can do what we ask given the stresses of single parenting. We would attempt to determine whether additional supports are available in the home, and the level of support available through extended family, relatives, friends or agencies.

Even the degree of social support is important when it comes to the outcome of parent training. Wahler (1980), after extensive research of the effects of parent-management training concluded that the effects of parent management training may vary as a function of a parent's social contacts outside of the home. In their research Wahler and colleagues

noted that after mothers had positive contacts outside of the home (e.g., with friends) they were significantly less aversive at home in their interactions with their children.

From a treatment utility perspective, this means that our recommendations and suggestions may not be effective under conditions where the parent does not have the necessary supports available inside or outside the home. If we are to be successful with single-parent families, then it may be necessary to help them find or develop the proper support systems, such as:

- Singles groups
- Baby sitting so they can go out
- Support group for parents with children who
- ETC.

Marital discord is surely a risk factor. There may be arguments over many issues that erupt into yelling, screaming and sometimes physical altercations. Sadly, these disagreements frequently occur in the presence of the children and may represent Setting Events that influence the child's behavior now,

When we do an assessment we must attempt to determine whether the parent can do what we ask given the stresses of single parenting...

later and across settings. Our experience has been that when the parents are having significant interpersonal difficulties, they frequently disagree and argue about and over the children. They disagree about the nature of the prob-

lem, who is responsible for the problem and how to manage the problem. Unless parents can come to some agreement, it is unlikely that they will agree on how to implement the recommendations of a consultant or trainer.

Needless to say, if something is not done to resolve the issues, it is unlikely that the behavioral support plan will be effective.

Our assessments often determine that previous behavioral services did not take broader family issues into account and their possible impact on outcomes. The assumption seems to have been that these don't matter and the family will pull together to do what is right. This "putting on the blinders" approach is a waste of time and resources. For behavioral services (e.g., parent training) to be effective, explicit efforts may need to be directed at resolving some of the discord existing between the parents either before or during services. Griest et al. (1982), for example, investigated the effects of dealing with parental relationship issues on the outcome of parent training. They compared the effectiveness of various forms of parent management training (e.g., traditional parent training alone, and parent training plus discussion of family relationship problems (e.g., parental personal adjustment, marital adjustment, parent perception of behavior, extra-family relations). Both groups showed sig-

nificant improvement over a no-treatment control group. But at a 2-month follow-up, improvements were maintained significantly better only in the group in which parent and family problems were addressed. The result of this study suggest that **successful treatment of a child's behavior problems may require explicit consideration of and attention to the interpersonal context in which the behaviors occur.**

Therefore, as part of a Mediator Analysis questions and exploration needs to focus on the conflicts in the family that might preclude effective implementation. Some specific questions that might get at these issues include the following

- How are you and your husband getting along?
- Do you have open arguments? What do you argue about?
- Do you agree on how to manage your child's behavior? On what do you disagree? Agree?

We may be able to get at the answers to these questions by asking parents to describe the methods they use to manage the child's behavior, to describe what works and what does not work, to describe what they do as a family, and to describe why they think the behaviors occur. Based on these descriptions, we may be able to identify unstated disagreements and difficulties.

Disagreement Around the Focus of Behavioral Support. The likelihood of our recommendations being carried out by parents or staff may be a function of the degree to which they agree on the **problem** that is causing them the most difficulty. One parent may feel that refusal is the big problem, while the other may feel the child's

tantrums are the most disturbing. What is the likelihood that the things we recommend will be carried out if there is no resolution of their disagreement? The same disagreements might exist between staff, between staff and supervisors, between staff and administrators, and between administrators and consultants. Indeed, staff bickering is one of the most frequently cited reasons in agencies for plans not being carried out as they have been recommended.

In the Mediator Analysis, we attempt to identify disagreements that may interfere with consistent implementation. Subsequently, we attempt to resolve these conflicts. This may be through explicit negotiation with a funding agency. It might involve reframing the focus from an objective, assessment-based, position. It might involve satisfying everyone by prioritizing for foci or addressing all of the concerns at the same time. Needless to say, if something is not done to resolve the issues, it is unlikely that the behavioral support plan will be effective.

D. Emotional Resources. Sometimes those who work with people who have challenging behaviors get to the point that they **can simply do no more.** A question that needs to be answered is whether the mediators have the **emotional resources** to carry out the recommendations. We have heard people say things such as "I am at my wits end." "I just don't know what I will do if he does it again." "I've just had it." Statements such as these suggest that the person's **emotional resources** may be at an extreme low ebb and may not be able to do more. This means that they may not be able to carry out recommendations consistently or at all. Indeed, making certain rec-

ommendations, without considering the person's emotional state, may push the parent or teacher over the edge, to the point of resorting to severe management techniques or to the point of premature placement or expulsion from the school program.

The does not mean that a behavioral support plan cannot be effective. Rather recognizing that people **do not have the emotional resources** we may need to suggest separate services or supports for the parent or staff. We may even recommend the temporary infusion of resources into the setting to give the mediator a respite. This might come in the form of respite services, in home intervention, before and after school services, all designed to reduce the amount of stress experienced by the parent.

E. **Physical Resources.** Many of the people we serve are extremely aggressive; they are large and when they hit there is a very real potential for injury. The question we need to answer is whether the mediators have the **physical resources** to carry out the recommendations? Can they keep the client and themselves safe during an episode. Here is an example that illustrates this point:

We recently conducted an assessment for an 11-year-old boy with brain injury who manifested physical aggression and self injury. The self injury was of major concern because it involved gouging his eye, stabbing himself with sharp objects in the forehead, and extracting his own teeth. At school, he was supported by two, full-time aides throughout the day. At home, his mother was frequently alone with him while dad was traveling. Of course, everybody agreed that he should NOT be allowed to self injure. A number of strategies had

been recommended, but evidence suggested that over 80 percent of episodes of self injury required physical prevention and subsequent prone containment until he regained control. We found that at school, physical containment sometimes required up to four individuals.

The boy's mother explained that she was **PHYSICALLY** incapable of preventing his self injury. In lieu of this, she would give in and capitulate early to prevent injury or serious damage. But this did not guarantee that all self injurious episodes would be prevented. Indeed, once he was self injurious, she did not attempt to stop him; rather, she would wait for a period of time and hope that he did not do serious damage to himself.

Unfortunately, his mother had been criticized by the school as noncompliant and uncooperative for not setting limits and holding to these limits. What they did not realize is that she was physically incapable of stopping self injury once it began; which would be the outcome of setting limits with her son. Our Mediator Analysis s h o w e d rather clearly that the

boy's mother could NOT KEEP HIM SAFE if and when physical control became necessary. Further, in a circumstance when it was important for her to set limits and hold to these limits, she could only enforce the limits through physical means; which she was not able to do. Consequently, we recommended that two support staff be provided in the home setting during his waking hours.

In another example, a young man was referred to us because he had not been in a day program since he left school at the age of 22 years old. He was in his mid-40's. The purpose of the referral was to design a support plan that would gradually introduce him into a local workshop. Our assessment showed that he weighed more than 200 pounds and had tantrums that included physical aggression. Our assessment also showed that his mother had been injured in the past as a result of his aggression. During the assessment, his mother said that she would "do anything to help her son." Our concern was that she was in her 80's and that even minor frustrations might trigger further aggression. We were concerned about her safety carrying out the plan. She simply did not have the physical abilities to "keep herself safe." As part of our support plan we recommended that he have the opportunity to live in his own apartment (i.e., supported

making certain recommendations, without considering the person's emotional state, may push the parent or teacher over the edge...

living). But in the meantime we recommended that support staff provide services in his parents' home until a supported living arrangement could be established.

When we make recommendations, we need to consider whether the people who will be asked to carry out the plan have the physical attributes to carry out the plan. Are they fast enough to catch the person if he runs? Can they physi-

cally prevent a person from entering the street or leaving the safe area? Can they effectively physically contain the person if he engages in severe self injury and this is a necessary reactive strategy? In other words, in the Mediator Analysis we need to address the best physi-

In many cases, it seems that their meaningfulness as people is indistinguishable from their children's disabilities and behavior challenges.

cal match between the support staff and the person we are evaluating.

F. **Secondary Gain.** We sometimes mistakenly conclude that “everyone will do what is best for the person they are serving.” We believe that the parent will reliably attend classes on behavior management; we expect the owner of a group home will insure that support plans are carried out consistently so that children can move back with their parents; and we are sure that the 1:1 aide will do everything in his/her power to help improve the person’s behavior and to reduce the service. We often fail to recognize that parents, teachers, staff, and administrators **MAY HAVE GOOD REASONS FOR THE PERSON NOT IMPROVING.** In other words, there is a “secondary gain” or benefit if the person doesn’t improve. As part of our Mediator Analysis we attempt to identify possible benefits that might be accrued if the person fails to improve, which might act as a barrier to full implementation.

Scapegoat. Tharp and Wetzel (1969) talked about “The Needed Scapegoat.” They wrote: “If the pre-delinquent child provides the focus for family disharmonies, and simultaneously is the screen for them, the family will resist changing its pattern of consequence because the child’s improvement is punishing to the mediator.” In other words, the child’s behavior provides a social focus and deflects attention from the real problems in the family. If this is suspected, we must recognize that behavioral services may not be effective until the family problems have been resolved. As part of a complete behavioral support plan, we would recommend that the

parents/family participate in family counseling. We may go so far as to suggest that the family receive counseling prior to providing services focused on the child.

Social Value and Rallying Point. Have you ever sat with a group of staff in a lounge and listened to their conversations about the people they serve. It would not be unusual to hear one or two staff comparing their clients/students and their behavior problems in a one-upmanship manner. For some, having the **WORSE ACTING** clients is a badge of courage to suggest that they are able to do what no other can do, that they are unusually competent. During assessments we have heard staff say “I’m the only one who knows how to work with _____,” or “No one knows how to handle him like me.” Indeed, we have experienced situations where staff do not follow our recommendations because they feel we “Don’t really know what he is like,” or “Don’t really know Fred.”

We need to be sensitive to the possibility that a resident/client might not be improving because improvement might reduce the person’s value or worth in the eyes of his/her colleagues (i.e., She/he no longer has the worse acting clients).

Over the years, we have worked with a number of families where the problems of a child are a “rallying point” around which family, friends, and agencies provide attention, social contact, emotional support, financial support, and services. Because of the child’s **EXTREME** behavior challenges, the parents spend a majority of their waking days attending meetings, working with advocates, organizing causes, attending therapy sessions, and talking to friends and family about **HOW HARD IT IS.** In some cases, the child’s behavior challenges may be the only source of social contacts outside the home.

We have worked with some parents who, for most of their adult lives, have stayed at home to care for their disabled children, now adults. Their children have been their lives, their focus, and their vocations. In many cases, it seems that their **MEANINGFULNESS** as people is indistinguishable from their children’s disabilities and behavior challenges. It also seems that their feelings of self worth and belongingness to the family are closely tied to their children **HAVING BEHAVIOR CHALLENGES.**

Given these scenarios, the Mediator Analysis must ask (based on the information we have accumulated) “Is there a possibility that the parents/teacher/staff would ‘sabotage’ the support plan in an effort to ‘safe face’ or to insure their meaningfulness in the eyes of significant others.?” If the answer

is “yes,” then the support plan may need to specifically address increasing the mediators interests outside of the person’s behavioral challenges. In instances where we are talking about staff, teachers, consultants, we may recommend changes to break the interdependence.

The Glue That Holds Them Together. Some families may resist recommendations for out of home placement or move into the community for their children/adult-children, even though the problem is extremely serious and a change is necessary and/or appropriate. They may resist such recommendations out of fear that once the child is out of the home, the family will disintegrate.

One or both parents may recognize that the family remains together only because of the problems manifested by the child. For example, several years ago, this scenario played out in textbook fashion. We were providing services in the family home of a 16-year-old with the problems associated with autism. He manifested severe physical aggression and property destruction (average of 3 incidents per hour). Our services were designed to implement a support plan in the home setting until such time that a specialized service (group) home became available in the community (it took about a year). At the point of assessment and throughout the provision of behavioral services it was clear that the parents agreed on very little. Indeed there was some question as to whether they even liked each other. Their entire focus of life was around their son. About a month after he was placed, the parents separated (and eventually divorced). Clearly, without the “glue” of their son’s behav-

ioral challenges, the family could not stay intact.

As we conduct our Mediator Analysis, we need to address the possibility that our recommendations might not be followed because one or more members of the team are fearful that if the person improves, the family might not survive.

Financial Gain. There may be good financial reasons for a family or staff not to follow recommendations. Families may resist placement when there is no question that it is needed because they depend on financial support that the child or adult generates. This could be in the form of Federal or State Support (e.g., SSI, child support). Tharp and Wetzel (1969) recognized this as a problem in their description of Case #66.

They described: “*Our staff strongly urged a widowed mother to call the juvenile authorities when next her daughter, Annie, sneaked out of the house at night. The mother was unable to do so, because this might have resulted in the daughter’s being adjudicated delinquent. If the daughter were confined to a detention or correction home, the mother would have lost the pension which she administered for the daughter, and which was the family’s major support. It was economically unfeasible for the mother to behave in her daughter’s best interest*” (p. 130-131).

There is no easy answer to this problem. Until the problem is addressed, the therapeutically correct decisions may never be made.

The answer is quite complex. It may involve placing the family in contact with other social service agencies. It may involve helping one or both parents find employment. It may involve infusing services into the home (e.g., baby sitting, respite care) so that the parents can get jobs. It may involve infusing services (e.g., before and after school services, weekend services) into the setting which reduces the financial reliance on the client’s income.

G. Philosophical and Attitudinal Conflict.

The Need For Discipline. At IABA, we hold that it is not necessary to punish people to influence their behavior. We ascribe to a system of nonaversive, person-centered behavioral support (LaVigna & Willis, 1995). Not everyone holds our view. Some people argue that “punishment is necessary,” and ascribe to the view “spare the rod and spoil the child.” Some professionals argue that people with severe behavior challenges have the “right to treatment” with aversive strategies. Unless we change their minds, unless we are able to teach them a new view of people, the nature of their behavioral

*Until the problem is addressed,
the therapeutically correct
decisions may never be made.*

challenges and methods of support, it is highly unlikely that they will carry out our recommendations.

Tharp and Wetzel (1969) discussed the conflicts that arise when working with some school systems when they wrote, “there is the steadfast disinclination to employ available positive control. There

are many reinforcers which might be used to stimulate academic performance and which incorporate imaginative arrangements for educational practice, creating a climate of positive motivation and

*In the absence of
“philosophical agreement,”
it is unlikely
that...recommendations
will be carried out.*

experience. But this vision is a far cry from educational institutional practice. Thus, **even the limited and correctional use of positive reinforcement meets frequent resistance**” (p. 137). They noted that public education is “managed almost entirely through aversive control: suspensions, expulsions, ridicule, loss of hall-passes or library privileges, scolding, loss of varsity eligibility, and the like” (p. 137).

In the absence of “philosophical agreement,” it is unlikely that our recommendations will be carried out. Here are some examples of the philosophical conflicts around discipline we have experienced.

We have been working with an 11-year-old boy in an inclusive education setting. In the first two months of our provision of behavioral services he spent very little time in the class. Our support plan called for reinforcing him for approaching, entering and remaining in class as a first step. But school personnel, from the teacher to the principal, were obsessed with the concern that he would spend large amounts of time out of the class. They repeatedly asked “What are

you going to do to get him into class?” They suggested that we discipline him for not going to class and also suggested that we **MAKE HIM** go to class; this despite evidence that physical intervention or punishment would **SURELY** result in physical aggression; and more concerning, stripping naked and running around the classroom or school yard. If he did these things, in their eyes this would be sure evidence that he does not belong in an inclusive education setting. If it were not for his advocates and the family lawyers, our worst fears would have been realized.

In another instance, we were providing 1:1 support for a young girl both in her home and at school. Her behavior had been so intense prior to our participation that she had been placed out of state in a residential school. After a comprehensive behavioral assessment she was brought back home and services were initiated both at home and at school. One of the foci of the support plan was “going to school;” that is, she was reinforced for going and remaining at school. Our data showed clearly that she was spending significantly more time at school and her behavior was improving. But there were days that she would decide **NOT** to go to school. On those days, we had an alternative schedule including shopping, household chores, etc. We were unconcerned that this might be reinforcing her **STAYING HOME** behavior. We felt that the reinforcement for going to school significantly outweighed that for remaining at home. However, this was not sufficient for the girl’s mother. She **DEMANDED** that when her daughter refused to go to school,

she should stay in her room and **DO NOTHING FUN**. Despite evidence that her school attendance had improved dramatically in just a couple of months, despite reliable documentation graphically presented showing improved behavior, and despite evidence that keeping her in her room when she did not go to school would result in severe behavioral escalation and the need for physical intervention, the parents demanded that we take a disciplinary approach. We were never able to come to agreement on this issue. We chose to transfer and refer the behavioral services to an agency that would be likely to **DO WHAT THE PARENTS ASKED**.

Reinforcement As Bribery. The controversy over whether to use punishment or not is not the only point of potential conflict. Some parents and staff do not believe in the use of **REINFORCEMENT**. They view it as “bribery,” and see no reason for “bribing” the person to do what they are supposed to do. Some people may not reject all reinforcement, but may reject the idea of using a particular type of reinforcement; e.g., food, certain privileges. We have worked with parents who have the belief that if you use food as a reinforcement, the person will become a compulsive eater. (We have **NEVER** seen this side effect.) So, what is the likelihood that staff or parents will use reinforcement as we suggest if they believe that using rewards is bribery? Just about **ZERO**. If behavioral services to be successful, then we will need to either select other methods, or re-educate the people around the potential benefits of using positive reinforcement.

Interfering Beliefs. Beliefs about the person being served

might negatively impact people's ability to carry out recommendations. For example, staff after having been spat upon may say that the person "did it on purpose." In other words, they take it personally. It may be difficult for staff or parents to be positive or to deliver reinforcement to a consumer if they believe that the child is misbehaving "willfully," or the child "knows what he is doing." And some staff have difficulty with the idea of trying to teach people with severe to profound learning difficulties because they believe they are "too retarded" to learn. "Why try?"

Unless we are able to change the views held by parents/teachers/staff, it is unlikely that they will follow the plan or adopt our recommendations. It is the purpose of the Mediator Analysis to identify these philosophical/attitudinal impediments. Perhaps this can help explain why the person has not progressed. One purpose of the Mediator Analysis is to identify these problems up front so that we can plan to re-educate or suggest other alternatives.

There are many other beliefs that may intrude on the ability of mediators to carry out recommendations. In 1969, Tharp and Wetzel talked about "The Insistence on Equity." This is a major issue. Our experience has been that many support plans are not carried out effectively because staff, teachers and parents feel that ALL THE CHILDREN AND ADULTS NEED TO BE TREATED ALIKE. They need to follow the same rules and they need to experience the same consequences for their behavior. With these beliefs in place, it may be difficult to individualize support; but individualization may be the only way that behavioral services may have an impact.

Schools are notorious for holding these beliefs (codified in school rules). Students must be in class and they must not leave without permission and a hall pass. In class, students must sit and work for the prescribed time, and if they don't comply, they are disciplined. If a student has a tantrum or is assaultive, he must be suspended for a codified period of time.

Students with disabilities and who have Individualized Education Plans, are also held to the same standards and rules. Frequently, little recognition is given to the possibility that the person's behavioral challenges may be a reflection of his disability. For example, the student who is aggressive because he has no other way of communicating, the student who refuses to enter the class out of fear or because of a lack of tolerance for crowds, noise, etc., the student who strips his clothing off because this is the only way he is able to terminate the task or activity. While the field pays lip service to the concept of an Individualized Education Plan, it has been our experience that it is individualized only to the point that the RULES ALLOW.

As part of the Mediator Analysis it is important to identify the beliefs that might impede the implementation of a behavioral support plan. Solutions to these problems may be difficult. Identified up front, we may be able to re-educate the mediators; or we may be able to re-negotiate the rules to better meet the person's needs. Unless these problems are addressed,

progress may be limited or nonexistent.

H. Personal Emotions. There are many personal emotions, dislikes or biases that may negatively influence the ability of people to carry out our recommendations. Ask yourself these questions, "Are there behaviors or actions performed by others that disgust you? Are there actions performed by your clients or students that make it difficult for you to work with them effectively?" Some common examples of personally disgusting behaviors include nose picking, eating snot, physical aggression, directed spitting (i.e., snorting a large amount from above the soft palate, projecting it in your direction and hitting you between the eyes), feces smearing, feces eating, public masturbation, genital touching (yours). For a variety of reasons some staff, teachers, parents have difficulty with certain behaviors, while not others. We have heard staff say, "I'd rather him hit me in the face and knock me down than spit in my face." Here is one example.

...many support plans are not carried out effectively because staff, teachers and parents feel that all the children and adults need to be treated alike.

A number of years ago, we assigned one of our most competent behavior specialists to conduct a behavioral assessment and begin services for a person who had a long history of feces smearing, among other behaviors. Little did we know that our behavior spe-

cialist had a strong aversion to the smell and sight of feces (others'). During the assessment, the behavior specialist was smeared with feces, at which point the specialist vomited uncontrollably. We

They may bear such anger and resentment toward the individual that they cannot begin to carry out our recommendations...

learned several things from this experience. First, we learned it was not a good idea to ask this specialist to assess, treat, or supervise any clinical case in which the person had problems with feces smearing, feces eating, or simply having bowel movements in his pants. Second, we learned that given his revulsion, it was highly unlikely that this specialist could or would carry out a reinforcement program for the absence of the behavior, or would carry out toilet training; he simply would be unable to get close enough without vomiting. Third, we learned that likes and dislikes of particular staff need to be meshed to and with the behavioral challenges presented by the client. Not doing this would result in ineffective implementation; if implementation at all.

For some other people, they can't tolerate barrages of directed profanity and insults. Perhaps for moral reasons, they see it as wrong and consequently escalate as the person's insults become more personal. I would imagine that they **DO NOT TOLERATE ANY FORM OF DIRECTED PROFANITY FROM THEIR OWN CHIL-**

DREN. We had a recent experience where this was the issue; it nearly resulted in the termination of the person from our services because no one wanted to work with him. We were providing services for a young man in his own apartment. Our assessment failed to identify that he had a history of directed profanity, insults, racial slurs as challenges that would need to be faced. Because of the potential severity of the behavior which was the focus of our assessment, he was provided with 1:1

support 24-hours-a-day. The problem appeared within about 2 months of initiating services. He began screaming profanities and threatening our staff hundreds of times each day. As staff described, he hurled at them every profanity and personal slur they had ever heard. Because we were unprepared for these actions, we neither selected staff on the basis of their tolerance for these problems, nor did we prepare staff for these problems. Staff reported anger, and several staff burned out at being verbally accosted and either quit or asked to be transferred to another apartment. Unfortunately, there was turnover of the entire support team, from direct care staff to supervisors. At one point the question was raised whether the client could be served in the community.

Our answer to this problem was an ecological one. Recognizing that his current support team was "burnt out," we reconstituted another team in one of our other departments. In addition, we prepared staff, seniors, and supervisors for what they were about to experience. The **KEY** was finding people **WHO WOULD NOT**

TAKE HIS INSULTS, PERSONALLY. Of course other actions were taken, including the introduction of needed psychiatric and neurological services and revision of his support plan to focus on these additional behaviors. We learned that even the best staff and administrators may have limits.

For a behavioral support plan to work we must find a way of **MESHING** the challenges presented by the person with the **INDIVIDUAL LIKES AND DISLIKES** of the Mediators.

Anger is another feeling that can intrude on a mediator's ability to carry out our recommendations. It may be insurmountable for some mediators. They may bear such anger and resentment toward the individual that they cannot begin to carry out our recommendations because they have reached the "last straw." At this level of anger, the mediator may not deliver prescribed reinforcement because they are unable to see something they feel meets the criteria; in other words, they may **NOT BE ABLE TO SEE ANY GOOD GIVEN THE BAD.**

This level of anger is not difficult to identify. It presents in the person's tone of voice during the interview. It presents in comments that may be disparaging and blaming. These emotions may present quite frankly in tears and anger as the mediator discusses the person and his behavior. Once identified, the question is What do you do about it? On the one hand, if we have the resources, we might change the mediators. We might suggest that a different teacher, aide or staff be involved with the person. In some instances, we may recommend that the entire instructional or other support team be changed; one that doesn't carry

the ANGRY BAGGAGE. But this is difficult to do in a natural home setting. The parents may not be able to “bail out.” Here we might suggest ways of reducing the anger through providing additional resources (e.g., baby sitting or even an in-home support team [Donnellan, LaVigna, Zambito & Thvedt, 1985]) that separate the parents and child. We might also suggest counseling for the parents to help them deal with their negative emotions. Tharp and Wetzel (1969) suggested some other ways that anger might be mitigated. They wrote:

“The technique here is to choose an original target behavior which is particularly annoying to the mediator. The immediate correction of the particular problem will thus be gratifying to the mediator and make his cooperation more likely. For instance, if a small child is annoying the teacher by getting out of his seat without permission, in addition to being bad on the playground, and is also underachieving in arithmetic, the strategy should be to focus initially on getting-out-of-seat. With that ‘sandpaper’ removed from the relationship between teacher and child, she will be in a better position to cooperate in consequating the full range of problem behaviors” (p. 133).

- I. **External Constraints.** We pointed out at the outset of this article that many support plans are driven by a mistaken belief; that the plan can be carried out by the parents, staff, or teachers. In many instances, while the mediators may be motivated, they may not be able to carry out the recommendations effectively because of environmental constraints including insuffi-

cient time or financial resources; because of the demands for caring or teaching other children/adults in the same setting, etc. In other words, the demands of even a minimally acceptable support plan may exceed the abilities of the mediators to carry out recommendations (Kazdin, 1985). This is an extremely important issue since some research has shown that “external factors” (e.g., transportation, child care, work) are given as the reasons for dropping out in 55 percent of cases (Garfield, Affleck, & Muffly, 1963).

It is our role in the Mediator Analysis to identify factors that might negatively impact the mediators’ ability to implement our recommendations, and to determine whether the plan can be realistically implemented given the evident constraints.

1. *Monetary Demands.* Some of the demands may be monetary. The families may not have the funds available to purchase reinforcers, or to hire baby sitters so that they can attend therapy or training sessions. Some families may not have transportation to get to and from the designated training locations. This does not mean that the families should not receive services; rather, it means that adaptations and modifications will be needed. For example, some programs have provided telephone resources, others have provided assistance with transportation, and child care (e.g., Horne, & Patterson, 1979).
2. *Too Much To Do and Too Little Time.* When we conduct be-

havioral assessments worldwide we frequently conclude that the previous recommendations were not implemented, not because people were non-compliant or unmotivated, but because they simply did not have enough time. Let us ask, how many of you parents or teachers could consistently

- record every occurrence of self hitting that occurs at a rate of one incident per minute;
- reinforce your child every 10 minutes with praise and a token for the absence of screaming;
- sit your child on the toilet every 30 minutes for 10 minutes;
- give attention every five minutes on a noncontingent basis.

While these recommendations may be important; as good as they may be, they may not be realistic given the demands that exist in the setting.

In the endeavor to deter-

...while the mediators may be motivated, they may not be able to carry out the recommendations effectively because of environmental constraints...

mine whether there are constraints that would prevent the mediators from effectively carrying out the recommendations, we ask them to describe their work schedules, their other responsibilities, their social and

political commitments. We describe to them the commitment of time we feel may be necessary and ask very specifically whether they feel they can do what may be recommended.

*...we need to keep in mind
... not all clients can be
treated or supported under
ALL conditions...*

3. *Staffing Resources.* The ability of mediators to carry out our recommendations will depend on the number of OTHER PEOPLE for whom they are responsible. A parent who has one child with behavior challenges may be able to do a lot more than a single-parent with three other young children in addition to the target child. Staff of a group home with a 1:3 staff to client ratio may have difficulty carrying out recommendations (a) if there are several other children in the setting with severe behavioral challenges, (b) if the other residents require considerable hands on care and direct teaching, (c) if in addition to their client responsibilities, they have total responsibility for the care of the physical setting.

Given these issues, as part of the Mediator Analysis we attempt to determine the other responsibilities of the parents and staff; the number other children/clients who have behavioral challenges and/or require care, and the level of physical care required by others in the setting. Given our findings, it

may be necessary to recommend additional resources and/or to recommend the reorganization of the existing resources.

J. **The Behavioral Characteristics of The Person.** Whether a mediator will be able to carry out your recommendations will depend on the **rate, duration and severity** of the behaviors presented by the consumer. Something we need to keep in mind is that **not all clients can be treated or supported under ALL conditions.** Here is an example of the problem:

Gina is in her mid-thirties. She has problems associated with autism along with serious learning and communication difficulties. She had a long history of physical aggression and self injury. Our assessment determined that her physical aggression and self injury were largely (85%) due to the pain she experienced as a result of severe ulcers. When she would cycle through her ulcer, she would physically attack support staff over a period of 8 to 10 hours with very few breaks. Knowing this, at the outset of service initiation, we assigned 1:1 staff to support her. But it was not too long after beginning services that her staff complained that they were overwhelmed and could not effectively manage her behavior. After a period of troubleshooting (the clinical supervisor carried out the 1:1 support during a severe episode) the clinical supervisor concluded that her behavior was too severe, too intense and of such duration (with few if any breaks) that no single staff member could carry out the emergency strategies. As a result, during her cycles of severe behavior, two staff were provided. Staff would work with her no longer than 15 minutes

before another staff member would take over. This would continue until the episode or cycle ceased.

So, when we conduct a Behavioral Assessment, the Mediator Analysis needs to evaluate whether the mediators can carry out the recommendations given the rate, duration, and severity of the behaviors presented by the person they are serving. Consider these examples:

- A 4-year-old boy participates in a preschool class with a teacher an aide and 28 other students. He runs or wanders around the class 30 minutes out of every hour. During this time, he hits and slaps his classmates on the average of 15 times during the same period. He seems to be doing it for the fun of it.
- An 11-year-old boy with problems associated with autism lives with his parents. He has profound learning difficulties along with high rate self injury. Our assessment showed that he would hit his head as much as 150 times per hour.
- A 16-year-old boy with problems of autism and some minor learning difficulties lives in a group home with five other boys. The home has a 1:3 staff to client ratio. He is reported to run away and escape at every opportunity (i.e., He attempts about every 20 minutes). When he gets away, it can take several hours of staff time to find him and return him home.

These examples are illustrative of situations in which the recommendations would need to address the mismatch between the mediator resources and the needs of the focus person.

K. **Organizational Structure.** We are frequently asked to conduct behavioral assessments for people

who are in group homes, sheltered workshops, or classrooms. At the end of the assessment, we make recommendations and suggest very specific strategies that might be used. We are frequently asked to consult on a regular basis with a program and to provide training around, evaluation and updating of our recommendations. In some cases, each time we return to consult, there is a new face, a new person we talk to or consult with. We find that one person has no idea what was recommended the last time and we have to reiterate what has already been said. This is frustrating to say the least, and totally ineffective at the worst.

One role of the Mediator Analysis is to determine who will mediate the recommendations. We attempt to identify the person or person's who will take the recommendations and do what is necessary to insure that EVERYONE knows what has been recommended, and who will SUPERVISE the implementation of the recommendations.

In staff operated programs, there needs to be a management STRUCTURE to support the provision of behavioral services. Indeed, Thompson and Grabowski in 1972 emphasized this point when they wrote "...enthusiastic support from high-level administrators is the single-most crucial factor in establishing a behavior modification program" (p. 272). In a critical review of staff management practices in institutional settings, Reid and Whitman (1983) concluded "...where their (direct care staff) performance has been less than adequate, it is primarily the reflection of the ineffectiveness of the management practices currently operating" (p. 146).

As part of the Mediator Analy-

sis, we strive to answer questions such as those listed below:

- Who is the supervisor or manager?
- How often does the supervisor meet with staff?
- Is the supervisor supportive of staff?
- Is there a method of accountability present that will insure that recommendations are implemented?
- What needs to change in the organizations structure for the support plan to be implemented effectively?
- Who will have the responsibility for meeting with the consultant?

If necessary, we may recommend reorganization and/or reassignment of responsibilities, outside consultation, and/or changes to the management system (LaVigna, Willis, Shaull, Abedi, & Sweitzer, 1994).

- L. **Intra-personal Issues.** There are many factors within the mediator that might intrude on his/her ability to carry out recommendations. For example, many staff and parents we have worked with over the years have learning difficulties or mental illness themselves. They may have difficulties reading and remembering what they read, they may have difficulties understanding what they hear in lectures and in-services because auditory processing problems, or English may not be their primary language. In some instances, the parent may have psychiatric problems (e.g., schizophrenia, obsessive - compulsive disorder) which may make it difficult for them to carry out recommendations. During interviews, we may recognize issues such as these. This

may lead to some specific questions and probes to expose these issues. For example, we might give a parent a couple of paragraphs to read and ask them to answer some questions. Recognizing that the parent is having difficulty concentrating we might ask questions to get at a history of mental illness. We might explicitly ask whether the parent is receiving psychiatric treatment and for what reason. We might ask whether the parent has a history of mental illness for which they have received treatment. Surprisingly, the parents we have worked with are usually quite open and willing to discuss their problems.

Once the Analysis identifies these mediator issues, it does not mean that the person will not be able to carry out the recommendations. On the contrary, it means that we will need to recommend adaptations that will help the mediator understand what we recommend. We might recommend that programs be translated into the mediator's primary language or that it be explained by a translator so that they can better understand the recommendations. We might recommend multi-modality teach-

*...it means that we will
need to recommend
adaptations that will help
the mediator understand
what we recommend.*

ing for some staff who have difficulty learning in particular ways. We might recommend that plans be concretized in such a way that the schizophrenic parent can bet-

ter understand it. We might recommend a gradual introduction of behavioral services in a step-by-step fashion so as not to overwhelm a parent who has a history of stress induced psychiatric episodes.

M. Training Issues. Training is a critical component of a support plan. All too often, the training of mediators is less than adequate or nonexistent at all. The consequence is that support plans are either not carried out or carried out inconsistently or incorrectly (Anderson & Schwartz, 1986). In the Mediator Analysis, we attempt to determine whether the mediators have the training and knowledge to implement our recommendations. We ask questions to determine whether training exists at all, as well as the type and extent of training.

It is important to understand, that if training exists, it is usually in the form of reading training manuals and policies, and in-service/workshop training. Unfortunately, these methods are least effective in teaching staff the skills they need to carry out individual support plans. This is very important when it comes to understanding parents also. As part of parent training classes, parents read manuals, listen to lectures and are expected to take the information home and use it with their children who may manifest very challenging behavior. There is very little evidence available to show that parents can take what they read and implement the strategies effectively at home; similarly teachers.

These methods create knowledge and understanding; they don't impart skills. For some, who are already skilled in the area, they may be able to implement what they have read because it is not a far cry from what they are already

doing. If we want staff, teachers, and parents to carry out specific strategies, then other methods are necessary. We employ a method we have termed "Three-Tiered Training" (LaVigna et al., 1994). The basic steps of this training process include the following steps:

1. step-by-step description of each step of the strategy in the form of a written "procedural protocol";
2. the mediator reads, reviews the protocol and all questions are answered by a supervisor;
3. the mediator demonstrates that they understand the protocol either verbally or through a written test (i.e., they show verbal competence - tier one);
4. the mediator demonstrates that they understand the protocol by practicing the strategies described in the protocol with the supervisor or consultant, until they meet specified criteria (i.e., they show role-play competence - tier two);
5. the mediator is observed implementing the procedure and corrective feedback is provided (i.e., they show in-vivo competence - tier three).

As part of the Mediator Analysis, we not only evaluate the existing practice of training; but also we recommend the level of training that will be necessary to carry out the recommendations. It is our belief that unless the mediators are knowledgeable, unless they are properly trained and supervised, they cannot effectively carry out many of the recommendations that we make in our support plans.

Conclusion

In conclusion, we have tried to describe some of the considerations in performing a mediator analysis.

Most of our comments were aimed at identifying mismatches between what a person may need and the mediator characteristics that exist. This article has not addressed, except for some isolated examples in passing, many of the strategies that could be employed to overcome the mediator barriers that may have been identified. That topic will be addressed in a future issue of *Positive Practices*.

There is obviously a relationship between a mediator analysis and the social validity, i.e., acceptability of a recommended support plan. In an earlier issue, Kushlick, Trower, and Dagnan (1997) described the use of cognitive-behavioral strategies to effectively deal with some mediator issues. The topic of social validity will also be further addressed in future issues, as it may represent the most difficult outcome to achieve under certain circumstances.

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