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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 base-lines; 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 com-

plex 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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Editors' Note...

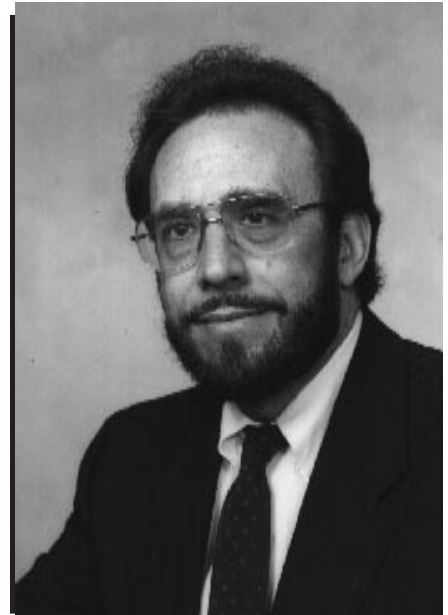
In this issue of the newsletter we begin a series of articles that will appear from time to time on the topic of assessment. The first article is an overview of this important area and will be published in two parts. Other topics in future issues will focus on antecedent analysis, mediator analysis, ecological analysis and other related issues. We look forward to your comments and questions about these articles as they appear.

We are also fortunate to have in this issue a report from Australia describing the creation of a Behavior Intensive Support Team service in the State of Victoria, based on the IABA model. We think you will be interested to see the results they have obtained, both in terms of behavioral and quality of life outcomes and in terms of cost effectiveness.

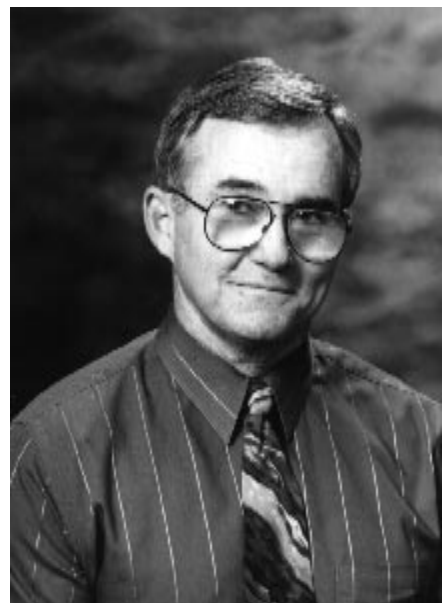
With the new responsibility of preparing this quarterly newsletter, we find ourselves working on it almost continuously. This past quarter, the preparation of this issue found us in Australia and New Zealand. It was our second trip to Australia and, in addition to 3-day seminars in Brisbane, Sidney, Adelaide, Tasmania, and Melbourne, we provided a second, two week Training Institute, which was attended by 36 people. It was very gratifying for our work to be so well and enthusiastically received. After our work in Australia, we then provided 3-day seminars in New Zealand, one in Auckland and one in Christchurch. These also appeared to be very well received and we look forward to returning there in the near future.

We hope you enjoy this issue of our Newsletter. Although we were very busy, we enjoyed preparing it for you.

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The Behavior Intervention Support Team Program: Addressing Challenging Behavior of People with an Intellectual Disability in Victoria, Australia

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Editors' Note: Gary Radler participated in IABA's Summer Institute in Los Angeles in 1990. His experiences there influenced the formation of the Behavior Intervention Support Team (BIST) system in Victoria, Australia. This Article is a preliminary report of the result achieved by BIST. In the section of the report discussing cost effectiveness, all amounts are reported in Australian dollars. This is designated by "A\$" throughout the report.

Introduction

It is estimated that 40,000 people who live in the Australian state of Victoria have an intellectual disability. No objective data on the prevalence of challenging behavior among this group was available until a study was conducted by the state government Department of Health and Community Services (Hudson, Jauernig, & Wilken, 1994). From data collected using a scale based on a section of the Inventory for Client and Agency Planning (Bruininks, Hill, Weatherman, & Woodcock, 1986), it was estimated that up to 5.3% of people with an intellectual disability residing in the community and 22.9% living in institutions demonstrated one or more challenging behaviors. The Behavior Intervention Support Team (BIST) Program was a component of a strategic plan to address the needs of these individuals, their families, carers and support staff. This article outlines the background to the development of the BIST Program; describes the objectives, composition of BISTs and the services they provide; and summarizes the major findings of a three-year, independent evaluation of the BIST Program.

Background

The 1980s were a decade of significant change for services provided to Victorians with an intellectual disability and their families. As in other Western soci-

eties, there was a movement away from the provision of institutional services as the main service type to the development of a service system that would support people to remain in their community. When families got to breaking point in

trying to cope with their family member's behavior, admission to an institution was less often used as a solution and by the end of the decade a "no admissions" policy was introduced. A growing network of Community Residential Units (staffed group homes in the community) was established which also meant that more often the community was exposed to individuals with challenging behaviors.

By 1989 a new landmark piece of legislation, The Intellectually Disabled Persons' Services Act (1986), was passed in Victoria. For the first time services for this group of individuals was separated by law from those provided to people who had a mental illness. It enshrined in legislation the movement towards integrating people with intellectual disability in the community and also gave statutory weight to the "least restrictive alternative" principle. Sections of this legislation governed the use of restraint, seclusion and aversive therapy and established an independent review body, the Intellectual Disability Review Panel, which would receive monthly reports of the use of restraint, seclusion and aversive therapy in all government funded services. At the same time other statutory bodies were established that led to an increased level of scrutiny of services for people with an intellectual disability in both institutional and community settings.

This trend away from institutions towards the establishment of a community based service system, together with the increased level of scrutiny of services for people with an intellectual disability, brought the issue of challenging behavior into sharp focus. The high level of challenging behavior among people living in institutions became clear, as did the restrictive ways with which these people were dealt, most often through the use of psychotropic medication as chemical restraint. In addition, the developing community-based service system experienced difficulties in addressing challenging behaviors of people who no longer were able to be placed in an institution. Finally, with a Government policy of relocating people living in institutions to the community, it was obvious that the community-based service system required strengthening in order to adequately ad-

dress the challenging behaviors of the people moving out.

It was upon this background that a strategic plan for addressing challenging behavior in people with an intellectual disability was developed. It included new training initiatives for direct care staff; supporting the tertiary education sector in establishing specialist Masters level professional training programs for psychologists; and establishing a funding pool which could be used to supplement direct care staffing so that individuals' challenging behavior could be addressed programmatically. The major new initiative of this strategic plan was the BIST Program. Over a three year period, commencing in 1990, a team of professionals in each of the nine regions of Victoria was established. These Behavior Intervention Support Teams provided a range of services aimed at supplementing and enhancing existing services' ability to address the needs of people demonstrating challenging behavior. The broad aim of Behavior Intervention Support Teams was to enhance the community's capacity to cope with and provide effective support and intervention services for people with an intellectual disability who show challenging behaviors and their families.

Behavior Intervention Support Teams (BIST)

Objectives of the BIST Program

At the commencement of the program in 1990, the formal objectives of the BIST Program were stated as follows:

1. To reduce the incidence of challenging behaviors in people with an intellectual disability.
2. To increase the knowledge and skills of families, carers and service providers in behavior intervention strategies.
3. To increase the skills of people with intellectual disability and challenging behaviors.
4. To increase the participation in community life of people with an intellectual disability and challenging behaviors.

Composition of Behavior Intervention Support Teams

After first being staffed entirely by mental retardation nurses and managed by psychologists, a review of the BIST Program in 1992 led to a decision that Behavior Intervention Support Teams could be staffed by people from a variety of professional backgrounds, including psychology, mental retardation nursing, speech pathology, occupational therapy, social work and teaching. However, staff recruited to the teams would all work to Position Descriptions that were essentially identical. This recruitment policy was adopted to ensure that the best people for the job were selected, regardless of their discipline background. The result has been that in the majority of cases Behavior Intervention Support Team positions are still held by mental retardation nurses and psychologists with the position of manager usually being held by a psychologist. Nevertheless, a number of positions are now held by staff from other professional backgrounds (mainly teaching) and this has resulted in a richer multi-disciplinary team approach, where a variety of professional perspectives have enhanced the service quality of the teams.

Intervention Model

The intervention model developed by the Institute for Applied Behavior Analysis (IABA) in Los Angeles provided the framework for the services of Behavior Intervention Support Teams (Donnellan, LaVigna, Zambitto, Thvedt, 1985; LaVigna & Willis, 1995; LaVigna, Willis, & Donnellan, 1989; Willis & LaVigna, 1995). This nonaversive treatment model leads to the development of multi-component intervention plans that include both proactive and reactive strategies based on a comprehensive assessment of the function of the individual's challenging behaviors. The proactive strategies include:

- ecological interventions (creating a better fit between the person and their environment),
- positive programming (skill building interventions that will lead to the development of general skills, functionally equivalent skills, function-

ally related skills and coping skills), and

- focused intervention strategies (e.g., differential schedules of reinforcement, stimulus control, stimulus satiation) that aim to produce rapid behavior change while the slower acting ecological and positive programming interventions take affect.

The reactive strategies are designed to avert potential behavioral incidents or to manage an incident in ways which minimize injuries to the person or others, or damage to property.

To assist in the development of the BISTs according to the IABA model, the state government Department of Health and Community Services sent its most senior psychologist to attend an IABA Summer Institute in Los Angeles in 1990.

Team Roles

Behavior Intervention Support Teams provide a variety of services including assessment services, intensive intervention support, direct behavior intervention, secondary and tertiary consultation services, and training and education programs.

Assessment Service

The BIST Client Assessment Service follows the process developed by the Institute for Applied Behavior Analysis. (See the article on behavioral assessment by Willis and LaVigna also published in this issue of *Positive Practices*.) This involves a file review, direct observations of and interaction with the client, interviews with the client's key social agents, and the completion of observational records and rating scales by these key social agents. This information is used to develop hypotheses about the function of the client's challenging behaviors, which are then used to develop recommendations about intervention. The method of information collection, the actual data, the analysis of this data and intervention recommendations are documented in a Behavior Assessment Report which is provided to the person referring the client. The Report also includes recommendations about the support and training requirements that need to be met to enable the client's key social agents to

carry out the recommended intervention plan.

Intensive Intervention Support Service

This is the BISTs' core service and commences with an assessment as outlined in the preceding section. When providing intensive intervention support, a comprehensive multi-component behavior intervention program is designed collaboratively with the client's key social agents based on the Behavior Assessment Report. In addition, a formal Service Agreement is negotiated that clearly specifies the nature of the service being provided by the BIST, and the respective roles and responsibilities of the BIST worker, the client's key social agents and their case manager. This Service Agreement also includes a specification of the agreed goals of the behavior intervention program.

After a behavior intervention program has been designed and a Service Agreement signed, the BIST worker provides structured and informal training in program implementation. In the first four weeks of implementation the BIST worker is required to spend a minimum of ten hours a week in the settings in which the program is being carried out to model intervention strategies, and provide support and advice relating to the program. A Supplementary Behavior Intervention Worker is also sometimes funded to increase staffing levels to assist with program implementation.

As the client's behavior improves and their key social agents become more proficient and confident in carrying out the program, direct contact time from the BIST is reduced. Contact continues to be made at least once every two weeks, until a formal review meeting is held following three months of program implementation. At this meeting the client's progress is discussed, together with the quality of program implementation and difficulties encountered. Changes to the program are considered and a decision is made about how and whether the BIST should continue to be involved. It is possible to extend the BIST service for an additional three months with formal monthly review meetings.

At case closure the BIST works to-

gether with the client's key social agents in developing a plan which will support the maintenance of positive program outcomes. Strategies that are considered include booster training, follow-up review meetings, and the provision of videos on program implementation.

Direct Behavior Intervention

This service also commences with an assessment as described earlier, and may be a stand-alone service or an adjunct to an intensive intervention support or secondary consultation service. This involves direct contact between the client and BIST where there is a need for counseling or some other psychoeducational intervention. For example, counseling aimed at developing victim empathy and reducing deviant sexual arousal through covert sensitization has been used with clients with a sex offending history.

Secondary Consultation

A secondary consultation sees the BIST providing advice, support and assistance to another professional or service provider in relation to a person with challenging behavior. At times it does involve seeing the client or their family members, but this is not always the case. Secondary consultation services have a twofold purpose: first, to assist in the development of a behavior intervention plan based on a functional analysis of the person's challenging behavior, and secondly to contribute to the professional development of the consultee.

Tertiary Consultation

With tertiary consultations the focus of assessment and intervention is not the client but a service agency or component of a service agency (e.g., a Community Residential Unit). Tertiary consultations are undertaken to improve an agency's performance so that challenging behaviors are prevented or are appropriately addressed. The Behavior Intervention Support Team will evaluate the agency's service design and practice and formulate recommendations for improvement. Often the Behavior Intervention Support Team assists in the actual application of these recommendations.

Training and Education Services

Together with the Disability Services Training Unit, Behavior Intervention Support Teams deliver a series of workshops to direct care staff across the state of Victoria on how to assess and manage challenging behaviors. The course includes an overview of the IABA model and exercises in applying it to a client whose behavior is challenging the training participants. Also included are sections from the Professional Assault Response Training curriculum (Smith, 1983), which includes training in the development of a self-control plan for staff when facing an assaultive incident, and a range of evasive self-defense techniques. In addition to this training, Behavior Intervention Support Teams design and provide a variety of other training and education programs to meet particular needs as they arise.

Evaluation of the BIST Program

In late 1989, the State Department of Health and Community Services called for expressions of interest from external agencies to evaluate a number of key programs introduced as part of the *State Plan for the Development of Intellectual Disability Services 1989 to 1992*. One of these programs was the BIST Program. In 1990, a A\$90,000 contract for the evaluation was awarded to the Disability Program Evaluation Unit, a unit jointly operated by academic staff from Deakin University and the Royal Melbourne Institute of Technology. The evaluation was to cover the operation of the BIST Program during the years 1991 to 1993.

From the outset, the evaluation of the BIST program was seen as being a collaborative exercise with continuous interaction between the government and evaluation team. The external evaluation was an elaboration of the self evaluation built into the regular activities of the BISTs. There were frequent meetings between the Principal Investigator and the Statewide and Regional BIST Managers, and representatives of the central management of the Department of Health and Community Services.

As part of the contractual agreement, the evaluation team was required to submit informative reports at six monthly intervals and a final summative report. Although the general direction of the evaluation was established in 1990, the detailed activities of the evaluation team and hence the content of the informative reports was decided at biannual meetings

Each intensive intervention conducted by the BISTs was evaluated using nine outcome measures.

between the Principal Investigator and the representatives of the central management of the Department of Health and Community Services. This arrangement was a very satisfactory one as it provided the flexibility for the evaluation to respond as necessary to changes in the requirements of the Department.

As a result of the collaborative processes outlined earlier, it was agreed that the evaluation team would focus on the outcomes of the intensive intervention component of the BIST activities. First, detailed data was collected on each intensive intervention conducted by the teams involved in the evaluation. Second, a cost benefit analysis was conducted on a selection of intensive interventions.

Results of Intensive Interventions Conducted by BISTs

A full description and evaluation of the outcomes of intensive interventions is given in Hudson, Jauernig, Wilken, and Radler (1995a), however a summary is provided below.

Each intensive intervention conducted by the BISTs was evaluated using nine outcome measures.

1. **Direct observation of challenging behavior.** Individual challenging behaviors were assessed by direct observational procedures. Primary care givers collected data on the occurrence of the behaviors each day

and this data was then graphed for visual examination of progress.

2. **Goal Achievement Scale.** To produce a quantifiable measure of success for each challenging behavior, a Goal Achievement Scale was constructed for each behavior for each client. This involved the BIST staff member and referring agent examining the baseline (pre-intervention) rate of the challenging behavior, and then setting in advance what rate of occurrence would constitute 100% success after completion of intervention. The actual post intervention rate can then be expressed as a percentage success ranging from zero (no improvement) to 100% (total success). Total success should typically mean the total elimination of the challenging behavior. This procedure was similar to but different from the Goal Attainment Scaling developed by Kiresuk and Sherman (1968).
3. **Aberrant Behavior Checklist.** This is a 58 item checklist developed by Aman, Singh, Stewart, and Field (1985) providing an overall measure of level of challenging behavior. The score range is from 0 (low) to 158 (high).
4. **Skill Level of Client.** This was assessed by using the items in the Vineland Adaptive Behavior Scale (Sparrow, Balla, & Cicchetti, 1984) as a criterion referenced checklist.
5. **Questionnaire on Resources and Stress.** This scale by Freidrich, Greenberg, and Crnic (1983) is a measure of stress in families. It has 48 items with a score range of 0 to 48.
6. **Baxter Stress Scale.** This scale was developed from assessments conducted on caregiver stress by Baxter (1987). There are seven Likert items with a total score range of 7 to 35. There are three subscales: Three items measure stress (range 3 to 15) with a high score meaning less stress, two items measure confidence in managing the challenging behavior (range 2 to 10) with a high score meaning more confidence, and two

items measure perception of knowledge and skill in managing the challenging behavior (range 2 to 10) with high score meaning more knowledge and skill.

7. **Index of Community Involvement.** This 15 item scale by Raynes, Sumpton, and Pettipher (in Raynes, 1988) measures the client's involvement in community activities. It has a range of 0 to 15. A high score means more involvement
8. **Index of Participation in Domestic Life.** This 13 item scale by Raynes, Sumpton, and Pettipher (in Raynes, 1988) measures the client's involvement in activities within the home. It has a range of 0 - 26. A high score means more participation.
9. **Consumer Satisfaction Rating Scale.** This scale was developed from a similar scale by Donnellan et al. (1985), and measures satisfaction with the program developed, the assistance given in implementing the program, and the outcome of the program. Each is measured on a range of 0 (low) to 4 (high).

In Table 1 there is a summary of the data collected for 134 intensive interventions which were completed in the evaluation period. The outcomes for many of the instruments used may appear a little disappointing, but these scales are global measures and they may lack the sensitivity to assess changes associated with interventions that focus on particular behaviors.

Many researchers in the area of challenging behavior would argue that direct observational data are the most critical in evaluation of intervention success. BIST clients typically had two or more (up to 6) targeted challenging behaviors. It was not possible to reproduce the hundreds of graphs in this paper, but inspection of them would show a wide variation in success rate. The external evaluators used visual analysis to rate the graphs on a four point scale of "change". The points were "showed substantial improvement", "showed moderate improvement", "no change", and "showed deterioration". Not all graphs were submitted to the external evaluators, and some were omitted from this analysis for particular reasons. Ex-

Cost Benefit Analysis of Intensive Interventions

It is recognized that challenging behaviors can generate enormous social and emotional costs for the clients concerned, and also for their families and other caregivers. The analysis reported here focused only on costs and benefits that could be given a dollar value. A full description of the cost benefit analysis is provided in Hudson, Jauernig, Wilken, and Radler (1995b). What follows is a summary of that analysis.

The first step in the cost benefit analysis was to calculate the cost of conducting an intensive intervention. The annual cost of staffing and operating the teams was divided by the number of intensive interventions completed in a year to produce a cost per intervention figure. This was calculated to be A\$5,725.

The next step was to calculate the extra costs incurred by a client having challenging behaviors. These are the financial benefits that would accrue following successful treatment. Ideally, this would have been done in a longitudinal fashion by comparing extra costs before and after successful treatment, but time and logistic constraints precluded this. An alternate methodology was adopted in which a sample of recently referred clients (N=11) were extensively studied in a retrospective fashion to estimate the extra costs that had been incurred because of their challenging behaviors.

The sources of extra costs examined were extra staffing costs, crisis and respite accommodation costs, medical and injury costs, repair and maintenance costs, and the costs of what was called lost support. The first four of these are self explanatory, but the last bears some comment. Often the presence of a challenging behavior results in the client getting increased time and attention from caregivers. This in turn can result in a reduction in the time and attention given by the caregivers to other clients in the environment. Ideally, the service system would remedy this loss by providing extra staffing. In reality, such extra staffing is frequently not possible and there is an actual loss of support experienced by the other clients. This can then be costed in dollar terms.

SCALES USED	Returned N=134	%	Change Range	Mean
Goal Achievement Scaling	73	54.5	0 to 100	75.6
Aberrant Behavior Checklist	126	94	-82 to 41	-15.9
Skill Acquisition				
<u>Daily Living Skills</u>				
Personal Subdomain	109	81.3	-4 to 67	6.2
Domestic Subdomain	109	81.3	-11 to 22	3.4
Community Subdomain	109	81.3	-16 to 21	2.1
<u>Socialization</u>				
Interpersonal Relationship Subdomain	109	81.3	-15 to 24	3.4
Play & Leisure Time Subdomain	109	81.3	-14 to 38	3.8
Coping Skills Subdomain	108	80.6	-12 to 15	3.1
<u>Communication</u>				
Receptive Subdomain	109	81.3	-7 to 15	1.9
Expressive Subdomain	109	81.3	-13 to 50	3.9
<u>Education</u>				
Literacy Subdomain	109	81.3	-3 to 22	1.1
Numeracy Subdomain	109	81.3	-3 to 28	1
<u>Motor Skills</u>				
Gross Subdomain	108	80.6	-3 to 18	1.9
Fine Subdomain	109	81.3	-5 to 16	1.5
Questionnaire on Resources & Stress	16	11.9	-8 to 22	-0.1
Baxter Stress Scale				
Stress	110	82.1	-5 to 11	2.2
Confidence	111	82.8	-5 to 8	2
Knowledge and Skill	111	82.8	-4 to 7	1.6
TOTAL	111	82.8	-7 to 26	5.8
Index of Community Involvement	125	93.3	-8 to 11	1.1
Index of Participation in Domestic Life	124	92.5	-18 to 22	1.4
Consumer Satisfaction Rating				
Program	124	92.5	1.7 to 4.0	3.1
Assistance	125	92.5	0.7 to 4.0	3.1
Behavior Change	123	91.8	0.0 to 4.0	2.9

Table 1 - Summary of Outcome Data for 134 Completed Intensive Interventions. From: "Regionally Based Teams for the Treatment of Challenging Behavior: A 3 Year Outcome Study", by A. Hudson, R. Jauernig, P. Wilken, & G. Radler, (1995). Manuscript submitted for publication.

amples of reasons were (a) the number of baseline points was insufficient to make a reasoned analysis, and (b) the baseline and intervention rates of the target behavior were very low and a rating of "no change" would misrepresent the actual outcome. A total of 158 graphs were visually analyzed and rated with 51 (32%) showing substantial improvement, 63 (40%) showing moderate improvement, 34 (21%) showing no change, and 10 (6%) showing deterioration.

The overall positive results of the direct observations are reinforced by the

Goal Achievement Scaling (GAS) and Consumer Satisfaction data. The GAS data indicates that the mean level of success for interventions was 75.6%. The range of success was from zero to 100%.

The mean score for the Behavior Change subscale of the Consumer Satisfaction measure was 2.9 on a scale of 0 to 4 (just under 75%). The mean scores for the Program and Assistance subscales were even better with both at 3.1. These results suggest that users of the BIST services are very happy with the outcomes of the BIST interventions.

The total extra costs for the 11 clients ranged from A\$2,284 to A\$132,697 per client per year, with a mean cost per client per year of A\$40,510. The mean cost per client by way of category were as follows: crisis and respite accommodation, A\$17,993; extra staffing, A\$9,377; medical and injury, A\$594; repair and maintenance, A\$2,613; lost support, A\$9,933.

On the face of it, the outlay of A\$5,725 for an intensive intervention would be a good investment for challenging behaviors which cost about A\$40,000 per year. However, not all interventions are successful, and not all successful interventions are free from relapse. If the 75.6% success rate from the Goal Achievement Scales used to evaluate the success of intensive interventions is taken as a guide, the intensive interventions carried out by the BISTs would still seem to very cost effective.

Summary and Conclusions

This paper has described the establishment in Australia of community based Behavior Intervention Support Teams (BISTs) for the treatment of challenging behaviors of people with intellectual disabilities. The teams operated on the basis of the model developed by the Institute of Applied Behavior Analysis in Los Angeles. An external evaluation of the Teams concluded that, while not all interventions resulted in success, the overall success rate was substantial. Further, it was concluded that this model of treatment was cost efficient.

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Behavioral Assessment continued from page 1...

understand the reasons behind a person's behavior, we must do more than simply define the challenging behavior, identify the antecedents and consequences (albeit these are extremely important). We need to have a good understanding of the person and the context in which he lives, works and recreates. We need have an understanding of the person's history, where he has lived and what he experienced in the places he lived. We need to have some understanding of the person's history of formal education; his successes and failures. We need to have an understanding of the person's development and family life; his experiences, his losses, his tragedies. In other words, in order to understand the reasons behind a person's behavior, we must attempt to "understand the person as a person living in a complex society." How do we gain this understanding? It is through a thorough behavioral assessment.

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), which incorporates variables from both the person's current situation and his or her past history. Our earliest and current approach to behavioral assessment involves the examination of at least eight critical areas. These include:

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.
6. Motivational Analysis.
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 fol-

lowing 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. For example, O'Neill and his associates have developed a *practical assessment guide* (O'Neill, Horner, Albin, Storey, & Sprague, 1990) that is intended to be quick and easy to use without any specialized training. There are other assessment methods and approaches that are equally quick and easy to use (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 assessment methods 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*.)
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 dis-

ability 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 grungy, dirty 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

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| <p>A. Referral Information</p> <p>B. Description Of The Person</p> <ul style="list-style-type: none"> • Physical Characteristics • Cognitive Abilities • Communication Abilities • Motor/Perceptual Abilities • Self-Care Skills • Social Skills • Community Skills • Domestic Skills • Leisure/Recreation Skills <p>C. Other Background Information</p> <ul style="list-style-type: none"> • Family History and Background • Living Arrangement • Program Placement • Health and Medical Issues • Service History <p>D. Mediator Analysis</p> <p>E. Motivational Analysis</p> <p>F. Ecological Analysis</p> <p>G. Functional Analysis of Behavior</p> <ul style="list-style-type: none"> • Description of Problems • History of Problems • Antecedent Analysis • Consequence Analysis • Impressions and Analysis of Meaning |
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Table 1 - Major Areas of Focus in a Comprehensive Behavioral Assessment

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 it is important to know what a person can and cannot do; first so that we do not ask or require the person to do things she cannot do; and second so that we know what skills we need to teach to give the person greater control over their life.

C. **Other Background Information.**

1. **Family History and Background.** It goes without saying that family context can have an immense effect on a person. Parental personality, family climate, marital relationships, and community support systems for the family can be potent influences on a child's behavior and development (Mash and Terdal, 1981). For example, some studies have shown that warmth and permissiveness of the home are significant factors in the effectiveness of social reinforcement by parents (Patterson, Littman, and Hinsey, 1964). Other studies have shown that maternal punitiveness can be influenced by the stress she experiences in the situation (Passman and Mulhern, 1977). Holmes and Rahe (1967), for example, observed that abusive parents had undergone significant life stresses (e.g., change of job, new apartment, major illness, changes in finances) in a twelve month period prior to the incident.

As part of the behavioral 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

"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?"

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

absence? For those of you who have suffered the indignities of military living, do you remember the impact of communal showers, living in large open

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

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

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 medica-

tions 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.

- 4/9/85 - Add Shock for touching food.
- 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 of 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

It is not unusual for people to spend years on medication with little or no benefit.

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

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

Not all support plans can be carried out under all conditions.

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

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

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.

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)

Physical Features of the Environment	Interpersonal Features of the Environment
<ul style="list-style-type: none"> • Setting • Lighting • Number of persons in setting • The behavior of others • Noise level • Personal space • Crowding • Arrangement of the Classroom 	<ul style="list-style-type: none"> • Expectations of others • Quantity and quality of interactions • Opportunity for interactions • The culture related to respect and dignity
Programmatic Features of the Learning Environment	Philosophical "Beliefs" in the Environment
<ul style="list-style-type: none"> • Opportunity for choice • Control over life's issues • Predictability • Instructional goals • Availability of effective reinforcers • Task order • Task difficulty • Task length • Instructional methods • Variety of materials and activities 	<ul style="list-style-type: none"> • "Spare the rod and spoil the child" • "They are not like real people" • "Must be cared for, not taught" • "They are just stupid" • "They need firm discipline"

Table 2 - Some Ecological Factors That May Affect Behavior

Definition of a Problem Behavior

Editors' Note: In this column, we tackle a problem we run into occasionally when performing a functional analysis, and that is defining a behavior problem that typically occurs outside of direct observation by staff. The description we provide below has been excerpted from a behavioral assessment report we prepared in support of a person who had been referred to us who was described as engaging in "Stealing" behavior. We decided to avoid this label because we felt it expressed a value judgment that might unnecessarily stigmatize the person we were being asked to help. Further, it seemed to us that concluding that a person has "stolen" is a legal decision and should follow due process. In contrast, a behavioral assessment and functional analysis should utilize descriptive labels not judgmental labels.

Because this behavior apparently occurred at a low rate and was typically not directly observed, you will undoubtedly note that the rate of the behavior reported in the assessment report makes reference to "conclusive" events and "inconclusive" events. However, a recommended support plan that follows from a comprehensive assessment process should include recommendations for how to carry out Observation and Data Collection to yield accurate, i.e., reliable data to be used in the evaluation of progress. Accordingly, we have also excerpted this section from the original Behavioral Assessment Report and Recommended Support Plan. It is included below following the description of the behavior.

When reading our recommendations for Observation and Data Collection, you may feel that they are intrusive and may compromise Mr. Nance's (our client's) dignity. This is a very serious concern and one that we shared as well. This was our thinking: Firstly, as you can tell from the below description of the severity of this problem, Mr. Nance was at risk of being tried for a crime and possibly imprisoned for engaging in this behavior. Our intent was to recommend a support plan that would be effective in preventing such an occurrence and the exclusion and further devaluation that would be likely to follow. In this spirit, our recommendations for Observation and Data Collection were included as shown below. Secondly, Mr. Nance was consulted prior to the finalization of the Behavioral Assessment Report and Recommended Support Plan. He was also very motivated to avoid the legal system. However, we explained to him that he had the right to either consent to or refuse to support our recommendations. He chose to consent. Finally, as indicated below, he was free to refuse cooperation with our recommendations at any time, which refusal would be respected by staff. Given these factors, we believe that our recommendations for Observation and Data Collection were justified. As always, we welcome any questions you may have about this.

Description of Behavior and Operational Definition of Unexplained Possession

A. *Topography.* An occurrence of Unexplained Possession is defined as Mr. Nance being observed **physically taking** something, from somebody or someplace, that doesn't belong to him. This includes but is not limited to such things as money, magazines, posters, cloths, food, drink, paper, pencils, etc. It is not

always something for which he has an obvious need, e.g., several bottles of "white out." It also includes his being **in possession** of something that is not on his inventory, for which he has no audited receipt of purchase and for which legitimate possession cannot be documented. It can include items taken from areas entered

into with permission, e.g., his own home, stores, place of work, and from areas that were entered without permission, e.g., a neighbor's house, other people's bedrooms, etc.

- B. *Cycle.* Each discovery (not item) is counted separately.
- C. *Course.* In terms of the course of the behavior, no precursors have been noted. Based on past records, however, he typically is or removes himself from direct observation; sequesters the item(s) someplace on his body; and then leaves the area, brings it home, and/or consumes it. If he brings the item(s) home, he apparently places it (them) in his room, not always with a careful effort to hide it (them). If it is money he has taken, when he spends it, he may not take as much care in hiding the item, since he "brought" it, albeit with someone else's money.
- D. *Strength.*
 - *Rate.* Conclusive occurrences have been documented to occur approximately once every month, with as many as five months in a row without any such conclusive events and very rarely with more than two in a single month. Although formal data have not been maintained, the rate of unrecognized or inconclusive events is very likely higher than this.
 - *Severity.* On rare occasion, the police have been involved. Most recently, this involved his formal arrest for having broken into his neighbor's home (a policeman himself) and allegedly taking \$500. While this was plea bargained down to trespassing, with six months probation, the judge has said that the next arrest and conviction will result in a prison term.

Observation and Data Collection

- A. *Procedure.* Staff should be assigned to carry out daily room and body scans. A body scan would involve

doing a 360 degree, visual scan of Mr. Nance's body within a three foot distance, but without touching him, while he is wearing only indoor clothing. A room scan would involve a full visual scan of his room, while standing in it but without touching anything. In addition, on a weekly basis, staff and Mr. Nance should carry out together a full inventory of Mr. Nance's room. Each discovery of Unexplained Possession should be summarized daily on a prepared form, indicating the Level and description of each event:

1. Level 1: Level 1 Unexplained Possession includes:
 - a. Direct observations of Mr. Nance taking something that does not belong to him.
 - b. Items or evidence of items in his personal possession or in his room:
 - i. that are not on his official inventory;
 - ii. for which there is no

audited receipt (an audited receipt is one that fits within the spending capabilities of the money that Mr. Nance had when he left the house); and

- iii. for which there is no legitimate documentation or independent confirmation justifying Mr. Nance's possession.
2. Level 2: Level 2 Unexplained Possession includes indirect or unconfirmed evidence as documented in a full and detailed incident report. Without a complete incident report, Level 2 cannot be scored on the daily data sheet.
3. Level 3: Level 3 Unexplained Possession occurs when Mr. Nance refuses to cooperate with the daily room and body scans or refuses to allow the weekly room inventory.

4. Level 4: Level 4 Unexplained Possession is scored when Mr. Nance self discloses or upon questioning admits to taking something that doesn't belong to him. To receive credit for a "self report", it must be made prior to the initiation of a room or body scan, room inventory, or the investigation of a Level 2 occurrence.
 5. Level 5: None of the above. This would be scored for the day if no Level 1 through Level 4 Unexplained Possession occurred.
- B. *Reliability Check.* A second observer should be assigned once each month to carry out a set of independent observations as described above. The results of these independent observations should be scored on a separate data sheet. Reliability should be calculated by comparing the agreements and the disagreements as recorded on the separate data sheets.

Procedural Protocols - Interactional Style

Editors' Note: The following protocols were contributed by Monique Gillissen, from Kent Town in South Australia. Monique participated in our 1993 Australian, two week Training Institute. She is now in private practice in South Australia applying the IABA model in the area of developmental (intellectual) disabilities. These protocols describe the interactional style that Monique recommended for staff working with each of two of her clients as part of their support plans. While they are obviously individualized antecedent control strategies, their parallel style and simple elegance illustrates that once the practice of writing procedural protocols is established, it doesn't necessarily require an enormous investment of time.

Our greatest hope for the IABA Newsletter is that it becomes a medium through which people who are dedicated to the advancement of positive practices in the field of challenging behavior can communicate and share ideas with each other. We are very grateful that Monique has started the ball rolling. We look forward to hearing from many more of you in the future.

Monique Gillissen
Private Practice, Kent Town, South Australia

Protocol #1

Name: Carol Spencer

Date Protocol developed: 10/03/95

Protocol name: Ecological strategies -

Interactional Style-Running Commentary

Materials: None, although this should be used in conjunction with the Daily Planner

Schedule: During all interactions with

Carol, particularly when approaching transition periods.

General Comment: Carol becomes anxious and upset when she is unable to anticipate what is happening next in her day and is reliant upon the verbal information provided to her by support staff. In order to reduce her anxiety and increase her responsiveness to requests being made of her, it is important that she receives this information and is assisted to understand what this means *prior* to changes of activities or transition periods.

Key Elements:

1. Gain Carol's attention prior to speaking with her. She is responsive to her name, and it is therefore important to use her name at the *beginning* of all interactions, so that she knows that what is being said is directed to her;
2. Await some kind of acknowledgment from Carol that she is attending before proceeding (she will often nod her head or make a small noise as an indicator that she is attending);
3. Using a 'story telling' tone of voice (as this communicates the idea of

“flowing” from one thing to another) and clear, simple language, explaining to Carol what is about to occur. This explanation should include either one or two steps as described below;

4. If the next task or transition involves Carol participating in a preferred activity, a single statement about what is happening next will suffice e.g. “Carol, it’s time to do...”
5. If the next task or transition involves Carol participating in a non-preferred activity, the explanation should be extended to include the next activity or transition and then also the one after that (which should be a preferred activity), e.g. “Carol, now we are going to do... and when we have done that, then we’ll do...” etc.

Comments:

The Daily Planner can be used as an additional point of reference during such interactions. This can serve to redirect Carol’s attention away from the person with whom she is interacting when she becomes upset. These interactions can also be used to help her understand that the Planner is a source of predictability and reliability, thereby encouraging her to use it at other times and reducing her reliance on the verbal explanations of support staff.

Protocol #2

Name: Terrance Murphy

Date Protocol Developed: 24/04/94

Protocol name: Ecological strategies -

Interactional Style-*Unconditional Assistance*

Materials: None, although this should be used in conjunction with the Daily Planner

Schedule: During all interactions with Terrance which involve making any kind of request of him, particularly requests to perform activities.

General Comment: Terrance becomes anxious and upset when he is asked to do things. Although many of the things that he is asked to do in the course of his day are well within his repertoire of skills, he becomes so panic-struck when he perceives that a request is being made of him, that he often does not hear all of what is said. There are also times when he does not understand what is being asked of him. He is very sensitive to ‘losing face’ and becomes assaultive when he feels cornered in this way. As ‘asking for help’ is currently not within his repertoire of skills (as this involves acknowledging that he does not understand or know something, which is akin to ‘losing face’), the following strategy was developed as a means of (a) increasing his tolerance of hearing requests; (b) giving him permission to seek and accept help, and; (c) teaching him the language skills involved in asking for help.

Key Elements:

1. Gain Terrance’s attention prior to speaking with him. He is responsive to his name, and it is therefore important to use his name at the *beginning* of all interactions so that he knows that what is being said is be-

ing directed to him;

2. Await some kind of acknowledgment from Terrance that he is attending before proceeding;
3. Make a simple statement about the task at hand, without giving a directive or making a request e.g. “Terrance, it’s time to do...”
4. Without hesitation or delay, immediately offer Terrance a *two-pronged question* in which the explicit offer of assistance is made together with the option of performing the task without assistance, e.g. “would you like to do it on your own, or shall we do it together?”, “do you want to do this by yourself or would you like me to help?”, “shall we do it together or do you want to do it alone?”
5. Be available to perform the task together and cheerfully do so, without inference that performing the task alone would have been a more highly valued choice.

Comments:

By offering assistance as one of two equally valid options, Terrance is not required to initiate the act of asking for help. This will help Terrance to understand that ‘asking for help’ does not mean having to ‘lose face’. The Daily Planner can be used as an additional point of reference during such interactions. This can serve to redirect Terrance’s attention away from the person with whom he is interacting at times when he is upset and help him to better anticipate the requests made of him in the course of a day.

In-House Training Opportunities Available

Whether you are looking for a one day workshop or a comprehensive competency based training program for your staff, IABA can meet your needs. We offer training on the following topics: Assessment and Analysis of Severe and Challenging Behavior, Positive Approaches to Solving Behavior Challenges, The Periodic Service Review, Supported Employment, and Emergency Management and Reactive Strategies within a Nonaversive Framework.

These programs have been successfully presented to audiences throughout the world by Gary LaVigna and Tom Willis. To arrange for a program to be presented for your agency or in your locality, contact John Marshall (telephone: [803] 731-8597; fax: [803] 731-8598; toll free: [800] 457-5575).

Resources

Training Calendar

Assessment and Analysis of Severe and Challenging Behavior

Gary W. LaVigna, PhD & Thomas J. Willis, PhD
 This competency-based training practicum provides participants with the clinical skills required to design a multi-element nonaversive support plan.
USA • Los Angeles, Ca. • July 28-August 10, 1996
England • October, 1996

Positive Approaches to Solving Behavior Challenges and The Periodic Service Review

Gary W. LaVigna, PhD or Thomas J. Willis, PhD
Positive Approaches... is a 2 day seminar that presents IABA's multi-element model for providing person centered nonaversive behavioral supports to people with challenging behavior. *The Periodic Service Review* is a 1 day seminar that teaches participants a staff management system that ensures the agency/school is providing quality services.

January, 1996 - US Seminars (Florida, Georgia)
February, 1996 - US Seminars (Virginia, North Carolina)
March, 1996 - US Seminars (New Jersey, Ohio, Michigan)
April, 1996 - US Seminars (Chicago)
May, 1996 - US Seminars (New Hampshire)
June, 1996 - London (Area), England; Cardiff, Wales
July, 1996 - US Seminars (Los Angeles, Sacramento)
August, 1996 - US Seminars (Colorado)
October, 1996 - Great Britain Seminars (London, Taunton, Manchester, Telford, Sheffield, Edinburgh); Oslo, Norway
November, 1996 - Australian Seminars (Perth, Townsville, Brisbane)

Supported Employment

Julie Shaull, Diane Sabiston, Chris Pellani
 This is a 2 day workshop that provides participants with all of the "nuts and bolts" of providing quality supported employment services to people with challenging needs.
March, 1996 - Great Britain Seminars (London, Manchester, Edinburgh)

Diagnosis and Treatment of Psychiatric Disorders in Persons with Developmental Disabilities

Robert Sovner, MD
 This 1 day seminar will examine current diagnostic trends and medication issues of people that have a dual diagnosis.
 Topics Covered:
 • Integrating Mental Health and Mental Retardation Concepts: Assessing Behavior from a Psychiatric Syndrome Perspective
 • Overview of Specific Psychiatric Disorders
 • How to Diagnose Mental Illness in Persons with Mental Retardation
 • Psychotropic Drug Therapy Overview
March 18, 1996 - Los Angeles

Other venues will be arranged and announced at a later date. For detailed, current information on any seminar, contact:

John Q. Marshall, Jr., Seminar Coordinator
Institute for Applied Behavior Analysis
 PO Box 5743
 Greenville, SC 29606-5743 USA
 Telephone: (864) 271-4161 • Fax: (864) 271-4162
 Internet: jmarshall@iaba.com
 Toll Free (USA and Canada): (800) 457-5575

Multimedia Training Programs

Competency Based Training Program

This is a systematic, criterion-referenced, self-instructional multimedia course for staff development that is customized to your agency. It is being used by adult service agencies and schools in Australia, Great Britain, Spain and the US. \$1,500.00

For more information on the CBT, contact:
 Diane Sabiston

Institute for Applied Behavior Analysis
 PO Box 30726
 Savannah, GA 31410-0726 USA
 Telephone: (912) 898-0390 • Fax: (912) 898-8077

Positive Approaches to Solving Behavior Challenges

This is a 6 module video training program that teaches viewers IABA's person centered multi-element model for developing nonaversive support plans for people with challenging behavior. Two text books, lecture notes and pre/post tests are included. \$1,250.00

Staff Supervision and Management Strategies for Quality Assurance

This is a 4 module video training program based on *The Periodic Service Review: A Total Quality Assurance System for Human Services and Education*. Viewers will learn concrete strategies to ensure that the highest quality services are being provided by their agency/school. Text book, lecture notes and participant exercises are included. \$750.00

For more information, contact:

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Printed Resources Available from IABA

Alternatives to Punishment: Solving Behavior Problems with Nonaversive Strategies

G.W. LaVigna and A.M. Donnellan
 "(This book) provides a comprehensive treatment of alternatives to punishment in dealing with behavior problems evidenced by human beings at various levels of development and in various circumstances. Based upon their own extensive observations and a thorough-going analysis of relevant experimental studies, (the authors) have put together a document that is at once a teaching instrument, a summary of research, and an argument for the use of positive reinforcement in the treatment of inadequate or undesired behavior... a landmark volume which should forever lay the ghost that aversive methods (even the ubiquitous 'time out') need to be applied to the delinquent, the retarded, or the normal 'learner,' whether in the home, the school, the clinic, or other situations." — Fred S. Keller (From the Preface to *Alternatives to Punishment*) - paper, \$19.50/ISBN 0-8290-1245-1

The Behavior Assessment Guide

T.J. Willis, G.W. LaVigna and A.M. Donnellan
 The Behavior Assessment Guide provides the user with a comprehensive set of data gathering and records abstraction forms to facilitate the assessment and functional analysis of a person's challenging behavior and the generation of nonaversive behavioral support plans. Permission has been granted by the authors to reproduce the forms for professional use. -spiral, \$21.00

Progress Without Punishment: Effective Approaches for Learners with Behavior Problems

A.M. Donnellan, G.W. LaVigna, N. Negri-Schultz, L. Fassbender
 As individuals with special educational and developmental needs are increasingly being integrated into the community, responding to their challenging behavior in a dignified and appropriate manner becomes essential. In

this volume, the authors argue against the use of punishment, and instead advocate the use of alternative strategies. The positive programming model described in this volume is a gradual educational process for behavior change, based on a functional analysis of problems, that involves systematic instruction in more effective ways of behaving. The work provides an overview of nonaversive behavioral technology and demonstrates how specific techniques change behavior through positive means. The extensive examples and illustrative material make the book a particularly useful resource for the field. -paper, \$17.95/ISBN 8077-2911-6.

Social Skills Training for Psychiatric Patients

R.P. Liberman, W.J. DeRisi, K.T. Mueser
 This guide to the application of social skills training with psychiatric patients systematically provides clinicians with the ingredients necessary to start and run their own social skills groups. Case examples, transcripts of social skills training sessions and exercises aid the reader in applying the training methods. -paper, \$25.95/ISBN 0-08-034694-4

The Role of Positive Programming in Behavioral Treatment

G.W. LaVigna, T.J. Willis, A.M. Donnellan
 This chapter describes the role of positive programming in supporting people with severe and challenging behavior. After discussing the need for positive programming within a framework based on outcome needs, variations of this strategy are delineated. Then, assessment and analysis are described as critical for comprehensive, positive, and effective support. A case study of severe aggression is presented to illustrate the process of assessment and analysis, the supports that follow from this process, and the long term results of this approach. - spiral, \$5.00

The Periodic Service Review: A Total Quality Assurance System for Human Services & Education

G.W. LaVigna, T.J. Willis, J.F. Shaull, M. Abedi, M. Sweitzer
 Evolving from more than a decade of work at IABA, this book provides the tools needed to enhance and maintain high quality service delivery. Translating the principles of organizational behavior management and total quality management into concrete policies and procedures, the *Periodic Service Review (PSR)* acts as both an instrument and a system. As an instrument, the *PSR* provides easy to follow score sheets to assess staff performance and the quality of services provided. As a system, it guides managers step-by-step through 4 interrelated elements — performance standards, performance monitoring, performance feedback, and systematic training — to offer an ongoing process for ensuring staff consistency and a high level of quality for services and programs. Practical examples show how the *PSR* is applied to group home, supported living, classroom, and supported employment settings, and the helpful appendices provide numerous tables and charts that can easily be tailored to a variety of programs. - \$36.00/ISBN 1-55766-142-1

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