Regional Center of Orange County

GUIDELINES FOR FUNCTIONAL BEHAVIORAL ASSESSMENT AND INTERVENTION PLAN FORMAT AND CONTENTS

Introduction

Behavioral interventions for persons with developmental disabilities are intended to provide the greatest opportunity for a life of dignity, individuality, productivity, and autonomy. Procedures include those that increase positive, adaptive behaviors and those that reduce maladaptive behaviors. Generally, the two complement each other and occur simultaneously. Procedures also entail varying degrees of intrusiveness. In accordance with Sub-Chapter 8 of Title 17, treatment programs must utilize the least restrictive procedure that will be effective in changing behavior. Whenever possible, positive behavior-enhancing procedures are to be used.

Depending on the services being provided and on the behavioral challenges being addressed, there may be differences in the level of analysis needed. As such, some sections as described in these guidelines may be deleted or collapsed when an in-depth analysis is not warranted. Additionally, these guidelines should be individualized based on the type and level of service being provided. For example, an assessment for an individual receiving Level 4i residential services or 1:1 behavioral day services will be more in-depth than one for an individual receiving 1:3 behavioral day services or for a child who needs toilet training and whose parents need behavioral consultation and training in their home.

Overview

A behavior assessment is a process for gathering objective information in order to build effective intervention plans. A behavior assessment goes beyond the definition of undesirable behavior. It aims instead at understanding the structure and function of behavior so that we can develop effective alternatives to behavior challenges and programs to teach them. Effective behavioral support should not just help reduce or eliminate a problem behavior. It should also change the opportunities a person has to learn new skills, to access meaningful activities, and to participate more fully in their community. In other words, behavioral interventions should positively affect a person's life quality as well as reduce problem behaviors. When behavioral interventions are provided in the context of providing services to individuals with developmental disabilities, the focus of intervention becomes as much the families or staff as the individual receiving services. The goal of any behavioral intervention is to make families or staff more effective agents when teaching and interacting with the individuals. Thus, behavioral assessments and treatment plans as described below focus on gathering the type of information most useful to family members and staff for this purpose.

The suggested format that follows should not be taken literally. Reports do not need to be lengthy but they must be comprehensive and complete. Thus, all relevant and important variables need to be included in each report.

Section 1: **CONSUMER IDENTIFYING INFORMATION**

Include name of consumer, date of birth, address, UCI number, primary language spoken or means of communication, referring service coordinator, and current diagnoses. Regarding the latter, use DSM-IV criteria that are used in the consumer's referral packet. If available and applicable, specify level of retardation. When reporting the current diagnosis, note the year in which the diagnosis was made (e.g., 1997 psychological report). Also include dates of consumer observations and the date of your report. All the information, observations, and facts stated need to be accurate and up-to-date.

Section 2: **REFERRAL INFORMATION**

The source of referral should be included (e.g., regional center and service coordinator). Also list referral behaviors. If discrepancies exist in referral behaviors across key social agents, please note this. For example, the regional center may indicate certain behavior problems that led to a referral to a Behavior Management Day Program, but when you interview the residential provider or family, other behavior problems may be reported. If referral behaviors or targets for change cannot be agreed upon prior to intervention, this will impact on your ability to evaluate progress over time. Additionally, describe the current reasons for seeking services from your agency. Why is the behavior a problem now? Typically, the behavior has been present for a while. What has happened to escalate it to a problem level? Has there been a specific crisis or precipitating factors that have led the regional center to seek services at this time? Any current and potential negative consequences of the behavior, such as threat of safety, physical damage, and placement in a more restrictive setting should be mentioned as well.

Section 3: **DESCRIPTION OF ASSESSMENT ACTIVITIES**

Assessment activities should include interviews, records reviews, and direct observations.

For interviews – include dates, settings, and the individuals you interviewed and their relationship to the consumer. For records review – include what records you reviewed (e.g., 1997 psychological report, 2001 IPP). For direct observation – include dates and settings in which direct observations were carried out. Other assessment activities should also be indicated here, such as interactions with the consumer, probes, or other tools used (e.g., Motivational Assessment Scale).

Section 4: **BACKGROUND INFORMATION**

Several subsections might be used to address important background information:

A: Consumer strengths and deficits: The consumer's strengths and deficits should be described including, but not limited to: cognitive and language skills, academic skills, and abilities in the self-help, daily living, social, emotional, and motor domains.

B: Living situation and family history: Describe the history of living arrangements and how the person was doing and why he or she was discharged. Also describe the person's current residential situation (e.g., family home, adult residential facility Level 4i, single or double room, etc.) and how the person is doing. If the person does not live at home with family, describe family involvement and the nature of family relationships.

C: School/day program placement and history: Please describe the history of school and/or day program placements, including dates, places, and how the person was doing and why he or she was discharged. Also describe the person's current day services situation and how the person is doing.

D: Medical conditions and medications: Describe the person's general health, any conditions for which the person currently receives treatment, hearing, vision, any previous illnesses or operations, history of seizure activity and whether controlled, any adaptive physical devices used and why. If applicable, list all medications, including purpose, dosages, schedules and potential side effects.

E: Language and culture: Please describe cultural issues that may either facilitate or impede progress (e.g., gender issues, language or communication barriers, cultural beliefs that should be considered when developing intervention plans).

F: Previous or Current Interventions Used: List any previous or current behavioral interventions implemented specifically to address the targeted behavior problem and describe their successes and challenges. Include any other interventions used to address the problem behavior (or related problems) and their effectiveness (e.g., psychiatric hospitalizations, in-patient referrals, counseling, medication).

Section 5: **FUNCTIONAL ASSESSMENT**

A functional assessment should be conducted for each target behavior. A complete functional assessment should include the following three phases: Descriptive Phase, Interpretation Phase, and Verification Phase. The Descriptive Phase includes an operational description of the problem behavior(s), its (their) history, and the antecedents, consequences, and environmental variables that might impact it(them). The Interpretation Phase synthesizes the information from the Descriptive Phase and develops specific hypotheses about the function (i.e., maintaining consequences) of each behavior. The Verification Phase helps determine if the hypotheses developed in the Interpretation Phase are valid. It does this by manipulating variables identified in the descriptive phase in brief, "mini-experiments," or by evaluating the impact of interventions based on the hypotheses formulated in the Interpretation Phase.

Descriptive Phase

A: Description of the Problem Behaviors

1. Operational definition: Include a label or "title" for the behavior and a brief description of the topography (physical characteristics) of the target behavior (e.g., What does it look like, sound like?). The key is to provide a descriptive picture of the

behavior so anyone observing would know whether they saw the behavior occur or not. It is helpful to provide an example when possible (e.g., if defining verbal aggression, give an example of what the person actually says). For example, "Hitting is defined as striking another person with a closed fist with a force that the blow is clearly audible at a distance of 5 feet and results in the person's body being deflected in a direction away from the blow; or the person who is the recipient of the hitting reports pain, discomfort, or injury."

2. Onset/Offset: Describe the onset and offset criteria for counting an occurrence of the target behavior. This is for recording purposes to ensure that all staff are counting occurrences in a consistent manner. For example, "An episode of kicking begins with the first contact of the foot to the body of another and ends when the behavior has been absent for five minutes."

3. Course of Behavior: Briefly describe how a typical episode of the target behavior unfolds and then comes to an end. Describe the presence of associated behaviors that are not the actual target behavior, but that reliably precede or follow the target behavior in the course of an episode. For example, the target behavior may be physical aggression, but prior to becoming aggressive, the person may begin pacing, pulling his bottom lip, and avoiding eye contact. These associated behaviors are not the target behavior, but they are part of a chain that reliably precedes the target behavior. Then, after becoming aggressive, the person may begin to cry and apologize, which may reliably signal that the episode is coming to an end.

4. Direct Observation Data: State the strength of the target behavior in terms of its frequency, duration, latency, and/or severity. Reports of the current strength of the behavior should be based on actual data collection procedures that have been implemented (e.g., event recording, time sampling). Describe the data collection procedures used. Please do not provide estimates based on family or staff verbal report.

   Direct observation of the behavior is a mandatory component in the functional assessment process (i.e., an assigned person should objectively record ongoing behavior). Event recording and time sampling are examples of direct observational recording methods (see Sulzer-Azaroff & Mayer, 1991 for examples of recording methods).

B: History: This involves stating the original onset of the behavior challenge, how long it has been a problem for the person (e.g., lifelong problem, started about 6 months ago), and recent changes in the behavior (e.g., increases or decreases in frequency or severity). Any events that may have contributed to a worsening of the problem should be described as well (e.g., the death of a significant other). State whether it is episodic (i.e., occurring at some times of year, week, more than others).

C: Environmental/Ecological Analysis: This section should describe the mismatches between the person's needs and characteristics and the current environment and how the mismatches might impact on the target behavior.

Please describe the nature of the physical environment and how it might impact on the behavior. This includes factors such as number of people in the person's environment, space, noise, temperature, sudden changes in the environment. Also consider the security of the environment and what physical alterations have been made to the environment (e.g., locks on cabinets or refrigerator, fences around property, alarms on doors)?

Further describe the programmatic environment and how it might impact on the behavior. This includes factors such as availability of reinforcers, materials, and meaningful activities. Is there any structure in the person's daily routine? What is the person's typical schedule during weekdays and weekends? Are schedules or visual aides available? Is there a variety of and access to activities and settings throughout the day? Does the person have opportunities for choice during the day? Does the person access the community? What instructional strategies are used? What level of family or staff supervision is provided?

Finally, describe the social or interpersonal environment and how it might impact on the behavior. This includes factors such as opportunity for and quality of social interaction with others, including individuals without disabilities, expectations of others, and the philosophy of those around the person, staffing patterns and interactions.

Based on your observations and interviews, articulate your impressions of family or staff resources and constraints, including potential ability and willingness to make necessary changes (scheduling, environmental, social interactions etc.) when interacting with the individual. Further describe the constraints on time, energy, and emotions. Stated differently, we are looking for an informal estimate of family or staff ability to implement your behavioral suggestions with the individual to influence a change in the target behavior. Is there any evidence that they will be able to set limits and follow through? Have they reliably kept data in the past?

D: Antecedents: Describe the events that occur immediately before an occurrence of the target behavior. When describing antecedents include the activities, times of day, locations, people, tasks, social demands, and environmental events that indicate a high or low likelihood that the target behavior will occur. For example, "sitting in the living room watching TV with three other consumers and no staff present."

If known, describe the setting events that may predict when the target behavior is more or less likely to occur. Setting events may occur hours, days, or weeks prior to the occurrence of a target behavior; they are not immediate events. Setting events might include mood, psychiatric status, medical or physical problems, sleep cycles, absence of medication, eating routines and diet, or emotional events such as an upsetting visit by relatives. For example, the immediate antecedent for physical aggression may be a request to complete a difficult task, but the person may be more likely to engage in

physical aggression when the request is given after a sleepless night or just before dinner or a favorite television show.

E: Consequences: This refers to events that occur immediately after the target behavior. Describe how other people react to the behavior. This may include reactions that are unplanned (e.g., peers move away and are frightened) and planned reactions (e.g., staff implement formal intervention strategy). Describe the apparent effect of these reactions on the person's behavior (e.g., is there a change in the person's posture, position in the room, verbal behavior?). Specific reactions or strategies used, and their effectiveness should also be delineated. In summary, describe the events that are maintaining the targeted behavior (e.g., positive reinforcement, negative reinforcement).

Interpretation Phase

F: Analysis of Meaning/Hypotheses: Based on the information gathered in your functional assessment, state your hypotheses regarding what is currently maintaining the target behavior. Describe what function(s) the behavior appears to serve for the person. The possible functions might include communication, initiation/maintenance of social interactions, stress reduction, increase/decrease of sensory input, escape/avoidance of unpleasant events in the environment.

Carr & Wilder (1998) describe this process as follows:

> "After many occurrences of the behavior have been collected, the next step is to look for patterns in the data. You might be able to find a time pattern; for example, the behavior usually occurs around 11:00 a.m. The next step would be to examine what is happening in the person's environment during this time period. Beyond time patterns, the primary areas of focus when analyzing descriptive assessment data are antecedents and consequences. For instance, the problem behavior might frequently occur after a request has been made of the individual. This might imply an escape function for the problem behavior." (p.11-12).

Verification Phase

During the verification phase, you will test the hypotheses stated during the interpretation phase. Two approaches are commonly used to test/verify a hypothesis. One involves experimentally manipulating variables identified during the descriptive phase and hypothesized to be controlling the behavior. This takes place during brief time periods in which direct observation occurs. For example, to verify that a behavior is maintained by social attention that follows it, you might alternate between 15-min. periods in which attention is provided after every occurrence of the behavior and ones in which the behavior is ignored. Higher rates during the attention condition support your hypothesis.

A second verification approach involves implementing the intervention immediately following the interpretation phase. The hypothesis will be verified through the data collected on the target behaviors. Thus, if the intervention is effective and the target problem behaviors decrease, then the hypothesis stated in the interpretation phase has been verified.

It is preferable to verify hypothesized functions experimentally if possible, as this can save valuable time. That is because interventions take a while to implement and for their effects to become apparent. If the hypothesized function is not correct, the intervention now has to be redesigned to test a new function.

Section 6: **DATA COLLECTION PROCEDURES**

Referring back to the "Direct Observation Data" section on page 4, describe the data collection procedures used. After the assessment period, new data collection procedures may be developed and should be described here. Again, please do not provide estimates based on family or staff verbal report. Keep data collection procedures in place to evaluate progress during the intervention period (i.e., verification phase). These ongoing data will help to determine whether continued intervention services are needed. In addition to staff data collection, conduct reliability or fidelity checks to assess staff accuracy and to identify behaviors that might be precipitating, reinforcing and maintaining the target behavior.

Procedures (e.g., daily tallies) and forms (e.g., daily or weekly data summary form) to be used for data collection need to be specified. Reliability checks, (that is, interobserver checks or procedural/fidelity checks) to ensure that data and observations are accurate, need to be described as well (see Sulzer-Azaroff & Mayer, 1991 for examples of data collection forms and information about reliability checks).

Section 7: **REINFORCER SURVEY**

Describe here any potential consequences that could be used to change the target behavior. Describe the method(s) used to determine possible reinforcers (e.g., reinforcer survey, direct observation, preference assessment). When conducting a reinforcer survey, look for things the person seeks unaided. Directly test preferences if possible. Also look at the outcome of your functional assessment. For example, if a person consistently exhibits difficult behaviors that lead to escape from situations, free time with no demands may be a highly preferred consequence. Consider using natural reinforcers first.

A list should be provided of potential positive reinforcers including; tangible, social, activity, edible, generalized (e.g, money) and exchangeable (e.g., tokens) reinforcers. If the list of reinforcers is short or if you have trouble identifying potential reinforcers, consider making suggestions for how to assess further for potential reinforcers.

Section 8: **ULTIMATE AND INSTRUMENTAL GOALS**

There should be a section indicating the ultimate and instrumental goals you want to accomplish.

A: Ultimate, or Long-Term Goals may focus on quality of life measures for the person. For example, the ultimate goal may be for a person to be in the least restrictive educational or residential environment. Ultimate goals also can be more specific to a target behavior. For example, an ultimate goal may be to eliminate physical aggression at home. However, the ultimate goal does not identify what you will do to help the person achieve the goal.

B: Instrumental, or Short-Term, Goals are the objectives that you want to accomplish by the end of the intervention/verification phase. Instrumental goals are based on information from the functional assessment and identify what you will do to help the person meet the ultimate goal. For example, using PECS to communicate rather than hitting would be an instrumental goal that would help the person meet the ultimate goals of eliminating physical aggression at home and having an effective means of communicating. Instrumental goals should be stated in measurable and observable terms. Changes expected during intervention should be referenced to baseline levels. For example, increase use of PECS to make requests from a baseline level of 10% of opportunities to 85% of opportunities within 90 days.

Please note that both ultimate and instrumental goals are stated in terms of consumer behavior. “Uses PECS to communicate” is an example, whereas “teaches PECS to communicate” is not. The latter is a goal for mediator(s)/staff, not the consumer.

Section 9: **INTERVENTION STRATEGIES**

In this section address the intervention strategies you will implement. Use your functional analysis to inform you of specific behaviors that provide the consumer with more appropriate and effective ways of achieving the same function(s) served by the target behavior. Then emphasize how your will teach the replacement behavior. The layout of this section should first list and define both the behavior(s) of concern and the replacement behavior. Second, the intervention strategies should focus on teaching the replacement behavior. For example, if an ultimate goal is to eliminate self-injurious behavior, an instrumental goal may be to teach the communication skills needed to replace it. The major focus of your intervention strategies would be on teaching communication as a means of accomplishing an instrumental goal leading to the ultimate goal of eliminating self-injurious behavior.

A. List and operationally define the behavior(s) of concern. Provide a baseline measure of the occurrence of target behaviors. Also, provide the function of the target behavior(s).

Behavior(s) of Concern	Baseline Measure	Function(s)
1.__________________	__________________	________________
2.__________________	__________________	________________

B. List and operationally define the replacement behaviors. Provide a baseline measure or the consumer's current skill level with the new behavior(s).

Replacement Behavior(s)	Baseline Measure
1.________________	________________
2.________________	________________

C. Goals

Ultimate: State the long-term (ultimate) goal. The goal should address the overall reduction/decrease of the behavior(s) of concern and increase in the replacement behavior(s). Please make this section consistent with the previous section titled "Ultimate and instrumental goals."

Instrumental: State the short-term (instrumental) goal. These are the objectives for the replacement behavior(s) that will be accomplished by the end of intervention. This section may be cross-referenced with the previous section titled "Ultimate and instrumental goals."

D. Mediator Training: Intervention strategies must include the method(s) of instructing the mediator(s) as to how to teach the replacement behavior(s). Intervention strategies are built around teaching replacement behavior(s), so it is critical to state how mediators themselves will learn to do this teaching. While positive behavior intervention emphasizes teaching new skills (replacement behavior), there will be times when the problem behavior will reoccur. Thus, use this section to describe how you will teach mediators to decrease/reduce the occurrence of the problem behavior when it occurs. Also describe how the mediator's progress will be measured.

E. Environmental/Ecological Strategies: Intervention strategies have taken into account environmental variables. The manipulation of environmental variables frequently increases the opportunity for the consumer to engage in the replacement behavior(s). Antecedent control strategies involve changes in physical, programmatic, or interpersonal environments. Through environmental strategies the mediators will learn how to contrive and capture establishing operations. Use this section to describe how the mediators will arrange the environment to provide maximum opportunities for the consumer to practice the replacement behavior. For example, if teaching communication the vendor would discuss how the mediator would arrange the environment to provide the opportunity for communication (contrive) and how to capture the opportunity when it is naturally occurring in the environment.

In addition, the manipulation of environmental variables frequently reduces the need for direct clinical intervention. Changes in setting events or immediate antecedent events may also prevent the occurrence of behavior challenges. For example, if a functional assessment identifies that an individual's aggression is escape-motivated and is primarily

exhibited when difficult or repetitive tasks are presented, intervention might include removing difficult tasks from the curriculum, shortening the sessions, interspersing difficult tasks with more enjoyable and easier tasks, or changing the materials or instructional presentation so that the tasks incorporate more preferred items. Furthermore, if the individual's aggression is more likely on days when he has not slept well the night before, his schedule may be arranged so that difficult tasks are presented in the morning rather than in the afternoon when he may be more tired.

Environmental/ecological strategies may help to capture opportunities to teach the replacement behavior and may also help to prevent the occurrence of the behavior(s) of concern.

F. Teaching the Replacement Behavior(s): In addition to environmental/ecological changes for teaching the replacement behavior(s), the vendor should describe how the replacement behavior(s) will be taught in a structured situation. For example, if the mediators will be teaching communication, then the vendor should state that the mediators will incorporate at least two 10-minute structured situations devoted to teaching the replacement skill. The vendor should also describe the topography of the structured situation. A description of how the replacement behavior(s) will be taught in an unstructured situation should also be provided. Additionally, structured reinforcement programs (e.g., differential reinforcement of zero [Ø] rates of behavior – DRO; differential reinforcement of alternative/ appropriate behavior-DRA; stimulus control) should form an integral part of a comprehensive behavior intervention plan. The time interval for reinforcement based on initial and ongoing data counts needs to be addressed. In order to ensure clinically appropriate implementation a number of variables need to be addressed clearly such as choice of an appropriate time interval for reinforcement based on initial and ongoing data counts, and selection and fading of reinforcers.

G. Generalization and Maintenance (Fade-out) Plan: Present a plan for generalizing the replacement behavior(s) to other settings and for maintaining them into the future. Generalization should extend across settings, persons, and activities. State how mediators will be taught to fade to intermittent schedules of reinforcement, to use natural reinforcers, and to raise criteria for obtaining reinforcement. State how the newly developed skills will be maintained in the natural environment to assure long-term success.

I. Data collection: This section should describe the data collection methods mediators will use to provide objective counts of consumer progress regarding both the replacement behavior and the behavior(s) of concern (e.g., daily tallies, duration). These should not be estimates. A criterion should be stated to determine when the mediator is reliable in using the methods. In addition to ways of monitoring consumer behavior, describe data collection methods that will be used to monitor mediator's progress.

M. Reactive Strategies/Emergency Procedures: Even while emphasizing new (replacement) behavior, the old behavior(s) of concern will express themselves during the course of the intervention. Thus, state specific strategies for managing the target behavior when it does occur. If the consumer resides in a facility, the reactive strategies should be consistent with the program design of the facility. Recommendations for responding when the target behavior occurs should be closely linked to the findings of the functional assessment. Reactive strategies should involve the least restrictive methods possible, while maintaining safety (e.g., active listening, cued relaxation, stimulus change before geographic or physical containment). A primary focus should be how to react early in the chain so the behavior does not escalate farther (e.g, respond to the pacing before it escalates to physical aggression).

Emergency procedures such as physical restraint, containment, etc. should be used only as temporary, short-term interventions with the immediate and primary aim of preventing harm. Emergency procedures are not used as punishment. If a consumer strikes out, but poses no further threat, emergency procedures would not be implemented. Please refer to Title 17 regulations regarding the use of a physical restraint and reporting requirements (Sub-Chapter 5, Section 50515).

Section 10: **RELAPSE**

Targeted behaviors frequently reappear regardless of how effective the initial intervention plans were in decreasing or eliminating them. Although relapse prevention is built into the maintenance efforts listed above, the reappearance of the targeted behavior should be anticipated. Consumers, their staff, and significant others should be prepared for relapse and not be discouraged or feel that their intervention efforts have been ineffective. The reappearance of a target behavior does not necessarily mean that an intervention plan must be reinstated either. However, consideration should be given to how you will prevent a lapse (i.e., one occurrence of the targeted behavior) from becoming a relapse (i.e., a return to the full-blown pattern of the target behavior).

Section 11: **SUMMARY AND RECOMMENDATIONS**

The number of service hours or staffing ratio recommendations should be specified here. If the number of service hours or the staffing ratio recommended represents an intensive intervention model, this should be reflected in the overall treatment plan. A clarifying statement should also be made in this section regarding the current need and reasons for intensive intervention at this time. Explain why additional resources are being requested, if they are, and indicate how long they will be needed and what behavioral criteria will be used for decreasing and eventually eliminating them.

Recommendations for assessments by other disciplines and services should also be presented here if applicable (e.g., updated psychological evaluation, psychiatric evaluation, medical evaluation).

Section 12: **SIGNATURES**

All reports must be reviewed and signed by a licensed or certified professional from the vendor agency (e.g., Licensed Psychologist, Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, Board Certified Behavior Analyst) and include the person's license and/or certification number.

Prepared by LeeAnn Christian, Ph.D., BCBA, John D. Cone, Ph.D., BCBA, and Junelyn Lazo

References Used in the Development of these Guidelines

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Willis, T., LaVigna, G., & Christian, L. (March, 2001). *Comprehensive functional assessment report and recommended support plan evaluation instrument*. Los Angeles, CA: Institute for Applied Behavior Analysis.

Other Resources

Books

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Journals

American Journal on Mental Retardation

Mental Retardation

JASH (Journal of the Association for Persons with Severe Handicaps)

Journal of Positive Behavior Interventions

Journal of Applied Behavior Analysis

Journal of Developmental and Physical Disabilities

Journal of Autism and Developmental Disorders

Web Sites

American Association on Mental Retardation - www.aamr.org

American Psychological Association - Division 33 (MR/DD) - www.apa.org/division/div33/homepage.html

Association for Behavior Analysis - www.wmich/psy/aba

Behavior Analysis Certification Board – www.bacb.com

California Association for Behavior Analysis – www.calaba.org

Cambridge Center for Behavioral Studies - www.behavior.org

National Information Center for Children and Youth with Disabilities – www.nichcy.org

The Association for Persons with Severe Handicaps - www.tash.org