STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF DEVELOPMENTAL SERVICES
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March 12, 1979

Dear Colleague:

These "Guidelines for the Use of Behavior Intervention to Restore Personal Autonomy - Aversive Behavior Interventions as a Specific Case", include standards and technical notes. They represent a thorough summation of existing legal, legislative and program state of the art considerations. The Introduction addresses critical, ethical, and societal issues that deserve to be fully respected and continuously reevaluated.

Through your collective help, the Department will refine these standards in the clinical situations where direct developmental services are being administered and provided.

Though the Department of Education has been an equal partner to the writing and design of these Guidelines as required by AB 1250, this draft has not yet been reviewed and approved by their leaders and public boards. This review will be accomplished prior to the finalization of these Guidelines.

We expect, at some point, to seek regulations. Thus, your serious attention and effort to assure that these guidelines are the best that we are able to do, to assure quality of life and human rights for the clients we serve, is truly needed.

I invite you to study and discuss this draft as widely as possible. Try the standards. The Department would appreciate any immediate reaction you have but need your comprehensive input by July 1, 1979. Please critically review both content and format to aid in facilitating the appropriate use of the standards for consumers, direct service workers, and administrators.

Sincerely,

Patrick L. Martin, Ph.D.
Assistant Director

Enclosures

CALIFORNIA

GUIDELINES FOR THE USE OF BEHAVIOR INTERVENTIONS TO RESTORE PERSONAL AUTONOMY

AVERSIVE BEHAVIOR INTERVENTIONS AS A SPECIFIC CASE

By: The Joint Task Force
California Departments of Education, Social Services, Health Services and Developmental Services
2/14/79

DRAFT

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CONTENTS

DRAFT
February, 1979

GUIDELINE ISSUES AND PRECONDITIONS

THE CONTEXT

The California Legislature, through various laws, has mandated that guidelines be developed regarding the use of those behavioral interventions which, while they may seek to restore personal autonomy, include the use of interventions which rely on aversive and/or noxious stimulus or events.

These guidelines, consisting of standards and associated technical notes, were produced in a major statewide, interagency collaborative effort to serve the needs of all settings providing educational or developmental human services. They are designed to provide a comprehensive single source for criteria to be adapted and applied to those settings and administrative systems within the Departments of Education, Developmental Services and those programs licensed by the Departments of Health Services and Social Services where behavioral interventions are applied.

The task is difficult and controversial. It is appropriate that it be so as the subject is one which should be scrutinized and addressed by all who are sensitive to human rights, the sanctity of individual liberty and the potential abuse of state power. The task is to establish guidelines aimed to regulate, and to block abuses in the use of a technology that under some conditions could constitute a nightmare of social control. Even when used by the best technicians, the most profound questions must be constantly asked and directly answered for we are dealing with a means that, even when intended to lead to ideal ends, require thorough prior ethical, philosophical and legal consideration. The human service system must regard the broad implications to the public's value system and social order must ultimately accept the responsibility when justifiable challenges arise against the use of these means.

The situation is further complicated by the fact that, often, justified use of these means is in programs for persons who experience severe handicaps who are often unable to competently communicate on their own behalf and who are most in need of assistance in order to restore their human dignity. The experience of these handicaps, compounded by the fragility of informed consent power, raises ethical as well as legal questions regarding the rights of such persons.

PREFACE

These guidelines were developed for the purpose of regulating the use of aversive and restrictive procedures in the education, community care, and health services and facilities of California. A Task Force made up of representatives of the California Departments of Education, Social, Developmental, and Health Services, augmented by recognized authorities in the field of behavior modification, representing a variety of viewpoints which included those of parents and child advocate groups, participated in the preparation of this document.

These guidelines follow the legal mandate for protecting individuals in California institutions embodied in the Lanterman Act, Assembly Bill (AB) 38002 (h), which states that a developmentally disabled person has "A right to be free from harm, including physical restraint, or isolation, excessive medication, abuse, or neglect", and (i), "A right to be free from hazardous procedures".

Consideration was also given to the many court decisions in which constitutional concepts have been developed for handicapped individuals which guarantee: (a) the right to privacy and dignity, (b) the right to treatment, and (c) the right to protection from harm.

A NATIONAL LEGACY

The past few years has seen an unprecedented change in the laws of the land, the attitudes of courts, lay persons and professionals regarding the treatment of those of our citizens in need of specialized services to ameliorate handicapping conditions. Until very recently, we as a society, tended to regard such persons as less able, less human, and therefore, as objects of a double standard of service. These public attitudes prompted the development of a variety of programs in our communities and schools which were "special" and meant to help the "less fortunate".

As "special", these services were often neither required nor guaranteed. Similarly, the treatment of the persons in these programs varied greatly in kind and quality and while many professionals labored to improve the quality, it was often from a sense of "nobless oblige", not from a compelling sense of civil rights. This charitable notion has as its correlate: what has been given can as easily be taken away. As a result, staff training and adequacy was never assured. Many programs were little more than depositories while others used procedures and interventions which were often socially and physically traumatic. The programs continued because parents/advocates were reluctant to protest as no other options were available and because the state-of-the-art was very under-developed. Even programs that were effective in bringing about behavior adjustment, despite unnecessarily harsh interventions were felt to be better than nothing and were rarely challenged. This was particularly true in the case of persons who tended to exhibit difficult behavior problems where highly punitive interventions were routinely used for even minor offenses and, in fact, sometimes to teach positive behaviors. It was in this context of societal rejection, limited resources, limited technology and a sense of "nobless oblige" toward persons with special needs that much of our field and its practices developed.

The courts typically saw "treatment" as beyond judicial scrutiny and only in the last decade, barring blatant abuse or cruelty, did it concern itself with intervening in programming or imposing legal quality safeguards. The absolute programatic ethic (if it works, it's appropriate) and a lassez faire legal attitude was relatively suddenly challenged with judicial intervention, then laws, regulations and standards that dramatically reversed era-old beliefs and practices. The scientific and service provider community were poorly prepared for the emergence of serious ethical and legal questions over matters which had always been taken for granted.

MATTERS OF PRIOR CONCERN

We would like to introduce these guidelines by asking some of these questions in the hope that basic legal and ethical issues can be clarified. These questions clearly apply to all persons, not just those who happen to have special needs. The answers are contemporary. They are based on the best professional and public judgment, given an evolving body, politic and scientific reality. Nevertheless, they must be regularly reviewed and adapted at least every two years to keep up with the relentless changes in the field.

1. GIVEN THAT PEOPLE HAVE A RIGHT TO LIBERTY AND PRIVACY, IS THERE EVER ANY JUSTIFICATION IN A CIVILIZED SOCIETY FOR USING AVERSIVE METHODS TO INFLUENCE A PERSON TO ADJUST?

The major, but not exclusive, concern of this document is for those children or adults who have handicaps which have resulted in their having been identified as needing "special" services, being removed from the regular developmental programs, and in many cases, removed from the community completely into wholly segregated "treatment" facilities. These placements outside of the "mainstream" of American life and social interaction have been seen by the courts as imposing severe limitations upon personal liberty. This liberty is protected by "due process" and "equal protection" clauses of the U.S. Constitutions 14th Amendment.

When a state takes it upon itself to restrict an individual's liberty or to treat a person unequally, the burden of proof is on the state or its agents to show that there is at least a compelling state interest to do so and/or that this treatment is leading to legitimate ends. At the very least, as Judge Frank Johnson expressed in the Wyatt v Strickney case: "To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for human therapeutic reasons and then fail to provide adequate treatment, violates the very fundamentals of due process". Similarly, the court in the Willowbrook case held that for the state to restrict an individual's liberty and allow him/her to worsen is equivalent to cruel and unusual punishment which is prohibited under the Eighth Amendment. Therefore, the rationale for removing a person convicted of no crime from free and full participation in society, which can be constitutionally justified, is in order to give treatment which will allow that person to gain and/or maintain a greater degree of autonomy and liberty

The reason for promoting guidelines rather than to prohibit the use of aversive intervention out of hand is to acknowledge that, in some limited cases where all appropriate alternatives have been tried and found wanting, the only legitimate treatment might include the use of an aversive intervention. Under those conditions, and those alone, such methods may not only be necessary but required to fulfill the right to treatment of the client.

2. HOW CAN ONE EXPECT TO MEET DUE PROCESS REQUIREMENTS AND ASSURE "INFORMED CONSENT" FROM A PERSON WHO IS POSSIBLY INCOMPETENT DUE TO AGE OR COGNITIVE ABILITY FOR A PROCEDURE WHICH, BY DEFINITION, THAT PERSON WOULD ORDINARILY ACT TO AVOID?

Aversive intervention as part of a treatment program is controversial because it may, in the extreme, entail imposing the will or direction of a professional - as an agent of the state - over a dependent subject without that person's full knowledge of, and consent to, the intervention itself. Even if these due process safeguards are met, ethical questions still remain.

It should be noted that several difficult and unresolved legal issues are involved in the utilization of aversive behavioral interventions. The primary unresolved issue is the possible conflict between the individual's right to treatment and habilitation services that foster the developmental potential of the individual and the right to refuse certain kinds of treatment.

For instance, the Lanterman Developmental Disabilities Services Act (Division 4.5 of the California Welfare and Institutions Code) in Section 4503(g) provides persons with developmental disabilities who reside in state hospitals, other health facilities, and community care facilities a right "to refuse behavior modification techniques that cause pain or trauma". This right cannot be denied by the facility operator for good cause, and minors 15 years of age and older may personally exercise this right of refusal. All persons with developmental disabilities also have a right to appropriate treatment and habilitation services. (See e.g., Welfare and Institutions Code Section 4502(a)).

Resolution of situations involving conflicting legal rights and interests of individuals and of society can come in several ways. The Legislature can clarify or elaborate upon the rights of individuals and the protection to be afforded to the exercise of such rights in light of other social policies. The courts may resolve such conflicts either on an individual basis or on a class basis. Administrative regulations or guidelines may also serve to resolve such conflicts, though these solutions can be overruled either by a court or by the Legislature.

While some aversive interventions are of minimal risk (e.g., "time out"), others are painful and involve the imposition of noxious if not traumatic stimuli. The desired effect of virtually all of these interventions hinges on the conditioning of a person's responses away from undesired behaviors. Often the subject cannot meaningfully "know" what the effect of the imposition of an aversive stimulus will be, since the subject's inability to aniticipate and move toward the desired behavior autonomously is often what calls for the aversive procedure. Thus, the question of when, if ever, it is appropriate to use behavioral interventions is clouded by lack of resolution of the question of the propriety

of non-consentual therapy, invasion of privacy and violation of the principle of not harming, in the course of therapeutic procedures. In this context, the limiting case of aversive behavioral interventions can be seen as the one in which a person:

1. Will be subjected to a procedure of more than nominal risk;

2. Is capable of giving consent, and

3. Is either a child or an adult who experiences mental disability or adjudged incompetence.

Further guidance for the conditons under which a person might be allowed to receive aversive behavior interventions is available from the National Commission for Protection of Human Subjects' recommendations for research of those institutionalized having a mental disability.

In the Commission's guidelines, the key phrase for nonconsentual interventions is clearly the concept that the intervention being proposed holds out the prospect of direct benefit for the subject, and is available only in the proposed context. We would substitute the phrase "proposed aversive behavioral" intervention as defined in these guidelines. Thus, the decision to institute non-consentual aversive conditioning hinges to a large degree on the justification that the procedure is in the subject's benefit. Because the field is relatively new, we might look to medical precedent for an analogous situation.

"Benefit", in the context of a child or an individual labeled mentally disabled who is locked into a behavioral repertoire which limits his/her interaction with peers, may be qualitatively different from "benefit" for a person who is striken with disease or illness. Transitory contact or meaningful interaction with peers might be construed as "benefit" in the first case. The often common experience between aversive behavioral interventions and more traditional medical ones is the imposition of pain in the course of therapy. For instance, the procedures needed to rescue a child from an acute illness such as meningitis are no less painful, invasive or non-consentual than are those of aversive behavioral interventions. While the presumption is that medical therapeutics are not in themselves intended to harm, any one who treats a partially comatose child knows that painful procedures (e.g., spinal taps) are often done in the name of therapy, even when such procedures are, in fact, only confirmatory or diagnostic in nature.

Thus, the question of benefit must hinge on another, more fundamental distinction. This second argument weighs ends and means. Presumptively, painful medical interventions, such as the example of meningitis above, are said to be justified because of their ability to restore physical health. It we accept this notion, we ought to have little difficulty with the notion that aversive conditioning for a self-destructive child suffering from autism might be equally restorative of well-being, i.e., more normal functioning.

The means taken to reach these ends are, however, quite different.

In the case of aversive conditioning, restrictions of the same nature as the disease itself can be said to be used such as the use of pain to reduce self destructive behaviors. While medical analogies doubtless exist, such as in the case of cardiac electroconversion to treat heart beat rhythm disorders, noxious techniques are generally discouraged under the primary dictum of primum non nocere, "first, do no harm".

The same dictum must hold in the use of non-medical interventions. In the case of aversive behavioral conditioning, the risk of harm is sometimes as great when the treatment is withheld.

Generally, the risk of using a procedure which is more aversive than necessary are these:

1. Potential physical harm or damage

2. Social stigma brought about by the intervention

3. Dehumanization

4. Continued necessity for aversive procedures (see Technical Notes)

If a given aversive procedure is necessary, but due to some extrinsic variable a less aversive procedure is employed, there are also risks to be weighed:

1. Slower effect

2. Lack of effect

3. Potential physical harm or damage

4. Social stigma brought about by the behavior

5. Dehumanization

6. Continued necessity for the use of aversive procedure

7. Potential need for long-term chemical or physical restraint to prevent the occurrence of the behavior.

This document, therefore, rests on the premise that each case is different and that one would not think of proceding unless the risk of harm from non-intervention was greater. The decision rests on the benefit to the client referenced to the ultimate restoration of personal liberty and autonomy.

3. EVEN IF WE GRANT THAT THE TREATMENT WILL BE OF BENEFIT TO THE CLIENT, ISN'T THE USE OF AVERSIVE BEHAVIOR INTERVENTION TANTAMOUNT TO THE WILLFUL EXERTION OF STATE POWER OVER THE POWERLESS?

As stated above, it is fully admitted that by definition the full protection normally afforded through informed consent may not be attainable and, in extreme instances, real abuse of power is always a threat. One where life itself is threatened can one justify non-consentual and heavily risk-laden "rescuing" interventions.

Assent to less intrusive procedures, while desirable, is not less difficult to obtain. For the non-verbal, profoundly psychologically or neurologically impaired individual, aversive behavior intervention almost can be presumed to void assent, since its very use automatically elicits objection by the individual or it is not truly aversive. Thus, the usual test of consent or assent is not feasible and the overall justification for aversive behavioral interventions must turn on the legitimacy of using restrictive measures to effect therapeutic ends absent consent or assent.

The use of any restriction on a person's freedom to act or behave autonomously is - on its face - a restriction of a fundamental personal right: liberty. This conclusion is unclear, however, when the action contemplated would act on an individual whose liberty is already circumscribed by significant behavioral disturbances. In this case, the decision can be one to further limit freedom in order later to secure a more complete liberty for the subject. Justifying arguments for such a decision can be found in Rawl's Principle of Justice in which the sacrifice of liberty is said to be warranted only for liberty's sake.

Aversive behavior intervention is an archetype of such a tradeoff, and, as such, brings at least two fundamental values into conflict with treatment: the right to personal privacy and the right to autonomy. While extremely complex, the resolution of any compromise of these rights is potentially based on the tradeoff principle enunciated above: one is allowed to violate the autonomy of a person when, and only when, that act is intended to increase the basal capacity for autonomy later. However, it is still critical to assure that the end of autonomy for autonomy's sake not vouchsafe any intervention. More will be said in the section below on Ends and Means.

4. WHY SHOULD WE ALLOW PEOPLE TO PUNISH A CLIENT FOR A BEHAVIOR WHICH, BECAUSE OF HIS/HER HANDICAPPING CONDITION, MIGHT BE BEYOND INDIVIDUAL CONTROL?

It is important to distinguish between aversive behavioral interventions and retribution for while they do not always differ in their means, they are fundamentally different in their intended application and end point. Aversive behavioral interventions consist of a range of techniques or strategies which have grown out of scientific research in the field of human psychology known as applied analysis of behavior. These procedures can be categorized as positive reinforcement, negative reinforcement, and punishment. Although positive reinforcement itself can be harmful if improperly used (that is, to produce "institutionalized" behaviors, cause stigmatization, etc.) these techniques are widely used, seldom abused and do not usually raise the legal and ethical concerns considered here.

Negative reinforcement is the termination of an aversive stimulus or event contingent upon the occurrence of a particular behavior. Its purpose is to strengthen that behavior. For example, if one is in a car which buzzes upon starting and the use of a seatbelt terminates the buzzer, the use of the seatbelt behavior will be strenthened and, hopefully, even in cars without alert buzzers. Comparatively little research has been done with human beings using negative reinforcement because of the effectiveness of positive reinforcement to strengthen behavior. As mentioned in Technical Notes, we do not advocate the use of negative reinforcement except under limited cirumstances and only when it is client initiated.

Punishment is used to reduce behaviors. It consists of either the introduction of an aversive stimulus contingent on a particular behavior or the contingent removal of a positive reinforcer. (This would include removing the person from a positive environment as in "time out".) Unfortunately, the very word "punishment" is laden with repulsive connotations for many people who see it always as an unwarranted intrusion upon privacy when delivered in a public setting or by public or private human service workers. We submit that this notion comes from a misunderstanding of the word punishment. Used appropriately(and that word is explained via these guidelines) punishment is highly complex and sophisticated and can assist people to gain greater personal freedom.

Retribution, on the other hand, is imposed to hurt and "get even", to make a person more blindly obedient and submissive to rules and social authority. It is rarely imposed to impare more spontaneity, to reduce fear, to eliminate constraints. By contrast, the appropriate use of punishment is in those limited cases where it is aimed at increasing autonomy, reducing fear and freeing the person from the constraintsimposed by the individual's own behaviors.

The analogy to acceptable medical practice is obvious. Subjecting a client to the very dangerous and painful rabies serum is appropriate and urgently needed when conditons warrant it and the treatment is being done by a qualified practioner. It is not retribution no

matter how painful. Further, no matter how aversive the intervention, if it is not used contingently and appropriately for the systematic reduction of a particular behavior, it is not punishment in the technical sense. Even the electric chair is not punishment - but retribution: "an eye for an eye".

Here and throughout this document we wish always to emphasize that we are not promoting the use of punishment but are trying to raise the issue above the mire of emotionalism and conjecture. When necessary for the liberty and autonomy of the individual, used under stringent conditions, as outlined herein, it may be appropriate and necessary in certain limited cases and must be a legitimate intervention to the professional in the best interest of the client.

5. THESE GUIDELINES ARE BOUND TO BRING ABOUT THE USE AND WIDESCALE ABUSE OF AVERSIVE BEHAVIOR INTERVENTIONS IN SETTINGS WHICH NOW HESITATE TO USE IT.

The argument that any guidelines will open the floodgates of abuse where not only a trickle may exist is bound to be raised. It is the position of some that aversive behavior intervention is not the legitimate purview of certain agencies or settings despite client needs. Such a position is tantamount to passive endorsement of the widespread abuses that currently exist (including) excessive chemical and physical restraint) and the entrepreneurial range of incompetent or inapproriate use of aversive behavior intervention. Recall that the spectre of such abuse promoted the Legislature to require that public departments create such guidelines in the first place.

To take the posture that the State should ignore existing unchecked, and essentially unmonitored, aversive interventions represents an untenable position that severely jeopardizes the consumer and our society. It is not enough to hope that abuse will not occur but to ensure that it is stopped and that the most humane and effective approaches to developmental behavior change are used.

Similarly, if one grants that there are those limited circumstances where aversive interventions must be used, one must acknowledge the necessity for giving guidance to teachers, administrators, nurses, doctors, residential staff, and other professionals who are attempting to use such interventions appropriately. Without such guidance, these human service managers run the risk of violating the rights of their clients unwittingly and/or being themeselves the false victim of some subjective accusations of abuse. As the matter is so obviously complicated and controversial, guidelines are essential. In addition, of course, this document requires that each setting which uses aversive interventions have a system for internal and external review which can allow for discretion necessary in any therapeutic or educational situation while still protecting client and staff alike.

Finally, the excuse that implementation of or monitoring of competence is not feasible because of the shibboleth of cost of resources and personnel needed in times of declining resources and social service cutbacks, is even less tenable. It is precisely when morale is at its lowest and shortcuts are sought to compensate for staff losses, that controls and regulation become all the more vital to prevent abuse.

6. TO WHOM AND WHEN DO THESE GUIDELINES APPLY?

Aversive behavior intervention (ABI) refers to a structured and consistent program of efforts which has as its goal the modification of maladaptive or problem behaviors and their replacement with behaviors that are adaptive and appropriate. ABI means all procedures which include either:

1. The contingent presentation of a stimulus or event which an individual would ordinarily act to avoid, or

2. The contingent withdrawal or termination of a stimulus or event which an individual would ordinarily act to maintain.

The guidelines contained in this document apply to any education, health or community care services or facilities when any of the following conditions are met:

1. When a person is removed to a more restrictive environment, program, classroom or service on the basis of his/her behavior.

2. When a question is raised about the appropriateness of a given aversive procedure being used or contemplated regardless of whether or not the agency recognizes it as an aversive procedure.

3. When a question is raised about the apparent denial of right to treatment because of a program's reluctance to use appropriate aversive procedure.

4. When a consequence exceeds the momentary withdrawal of social contact, such as exclusion from an immediate vicinity, intermittent termination of an intensive training session, or turning a person's chair away; extinction combined with selective reinforcement for alternative behaviors; or the contingent presentation of a mild aversive stimulus such as "no" or nonforceful physical prompts.

   Emphasis on the term "intermittent" because the removal or withdrawal is measured in seconds or minutes, not hours or sizable portions thereof, and the term "mild" emphasizes the likelihood that the stimulus will cause only minimal and temporary discomfort.

Wise and knowledgeable discretion must be exercised by professionals in making humane, ethical, and scientific judgment for the application of ABI services for individuals.

In conclusion, two issues emerge above all others:

ENDS AND MEANS: AN ULTIMATE DECISION OF VALUE

The thesis of this analysis asserts that at some point the ends of greater liberty justify means which restrict liberty.

For example, sufficient experience has been accumulated in the past describing the impact of isolation on an individual child (e.g., primate deprivation experiements, etc.) to justify extreme means to bring a child into contact with his peers. It is axiomatic that sociality is critical to the very life and social development of each child. Isolation from mothering and later from peers, limits meaningful social interaction which can result in an absolutely unacceptable human state. If an individual is unable to experience and carry out social intercourse and have access to a social world, one can say that the most critical and minimal precondition for human life itself is threatened.

Given all these considerations, it is the conclusion of this analysis that the benefits of aversive behavior intervention and the value served in the restoration of liberty and autonomy can outweigh the legal, moral, physical and psychological risks presented by the use of such interventions, as long as sufficient regulations and controls set forth in these guidelines are followed.

It is upon this premise that these guidelines are built - that the question is not whether a given intervention ought to be allowed or prohibited but under what conditions it might be allowed.

NORMALIZATION PRECONDITIONS AND PRINCIPLES IN ALL HUMAN SERVICES

The ethical and legal mandates which impact on our service delivery system require that we look at this philosophical underpinning of our service. Such a process raises many questions regarding the quality of our commitment to those who require extraordinary assistance in order to participate in our society. As a nation, we must ask these questions because our cultural institutions have not, as numerous European and non-Anglo societies have, uniformly embraced our vulnerable members as part of the family and as people deserving love, comfort, dignity and intimate relations. Stereotypes predominate. We seek ways to eliminate popular beliefs which are based upon what the public has learned from the past about disabilities. We must teach our fellow citizens to believe in society's capacity to emancipate people with special needs through new environments and our recent scientific achievements and successes in teaching. We must alter our own perceptions, and those of others, for as human beings the way we are perceived decides how we are treated in society. This is a matter of the very sanctity of life and one's identity for those who have disabilities.

We must ask ourselves what is the best way to assist people in society to achieve and to enjoy the fruits of that society. How do we assure that not only do we do no harm, but that we uplift the persons we serve in the eyes of their fellow citizens? How do we balance the clinical or educational benefit of using methods that improve competence and performance with the cost in status and reputation when culturally stigmatizing measures are employed? How do we protect the sense of personal well-being, confidence, dignity and pride of a person in a dependent relationship with services and staff who do not, or will not, identify with that person as a peer of equal worth? How do we recognize the right to treatment and social integration and help which each person possess in our society while eliminating ineffective programs which represent deprivations of liberty and impose overly restrictive alternatives?

California has adopted a philosophy of services based deeply in values. It sums up many of the deepest held beliefs assuring quality of life. These beliefs are at the root of our current and emerging civil rights and human services laws and standards. In order to grow, each person deserves:

-- love, honor and freedom from stigma throughout life

-- celebration of being special

-- a life-sharing family, home and nuturing support

-- a community of concern and friendship

-- economic security, health and the full benefit of modern technology with a varied continuum of services

-- the opportunity to grow, learn, choose, work, rest, play, be nourished, create, to experience well-being

-- solitude when needed

-- comfort and beauty in which to discover himself/herself

-- the power to improve his/her environment

-- justice

-- the dignity of risk, joy and growth of spirit

-- a valid social future

We are at this point in our search for answers to these terribly complex questions and situations. We have come to the perimeter of practice based in this philosophy and summarized in these guidelines. We intend that this document will be subsequently regularly improved as our knowledge and perceptions grow. In the

interim, we intend that it serves as means of guiding parents, professionals, clients and advocates to an understanding of a need for normalization in human services which accentuates the positive, which demands the use of means which are culturally normative in order to offer each person conditions at least as good as the average citizen and to as much as possible, enhance or support personal behaviors, appearances, experience, status and reputation to the greatest degree possible at any given time for each individual according to his or her developmental needs.

PART I

SECTION I

PLANNING AND SERVICE DELIVERY

This document has been developed to be applied to programs operated by a number of different agencies. These are the standards against which programs should be measured. Though they are not meant to be regulations, they do contain the essential legal and ethical program components which should be applied to all programs.

When the use of aversive behavioral interventions are contemplated in any setting, strict attention must be given to a well-established body of ethical and theoretical tenets of behavior modification.

This Section deals with planning and implementing behavior intervention programs.

A. AGENCY/PROGRAM

STANDARDS	TECHNICAL NOTES
1. Aversive behavior interventions may be provided for individuals in services or a facility only after that service or facility program has been reviewed and approved by the appropriate review committee.	
2. Services or facilities which provide aversive behavior intervention to individuals should/shall* have written policies and procedures that (a) describe the use of aversive interventions, the staff members who may authorize and implement their use, and a mechanism for monitoring and controlling their use; (b) describe the coordination and continuity of the total program for the individual; (c) are directed toward maximizing the growth and development of the individual by incorporating a hierarchy of available methods that emphasize positive approaches; (d) are available to all personnel, the individual, and his/her family.	2. See JCAH Regulations as well as PL 93-112 and the Lanterman Act (Division 4.5 of the Welfare and Institutions Code, Sections 4500-4825) for greater understanding of the affirmative obligations of schools and other care providers.
3. The record-keeping system must comply with the existing recording regulations which apply to the school, living arrangement, or activity program.	3. Record Keeping. Daily records older than one year may be kept separately. Records ought to contain the following kinds of information. a. Medical - In addition to the complete medical evaluation, all pertinent medical information such as allergies and other physical conditions which may have a bearing on treatment. This section should be first in the record.

* Should/shall references pertain to each department's degree of responsibility, i.e., "should" refers to the Department of Education, and "shall" to the Departments of Social, Developmental, and Health Services.

b. History - In addition to any other available history, a brief description of previous interventions performed at previous treatment facilities (typically not more than three pages) and at the present facility (typically not more than two pages). Interventions should be listed by target behavior. All interventions for a given target behavior should be listed chronologically.

c. Consent/Approval Forms - Must be signed for current programs. No ABI intervention program should be in effect without signed and dated consent and approval.

d. Goals of Treatment - This section should contain (1) the definition of all target behaviors, (2) types of reinforcement used, (3) types of aversives used, (4) specific contingencies employed, (5) type and method of data collection, (6) the long-range goals, (7) the time requirements for each goal, (8) the names of all persons assigned to carry out the interventions, (9) current curriculum or program designed for the individual client, (10) objective evaluation criteria, and (11) schedules for determining at least annually whether objectives are being met.

e. Progress - This section should contain summaries of data collected on all target behaviors. In addition, 2 concurrent graphs should be maintained on all rate, duration, and percentage tabulations: 1 graph which shows the daily progress (not more than 48 hours in arrears) and another that depicts weekly results (not more than 5 days in arrears).

STANDARDS	TECHNICAL NOTES
	f. Assessment - The result of all standardized and interim referenced assessment should appear here. All assessments should be dated and the tester identified. All entries desired by parents or surrogate should be included here, specifically the results of independent assessment requested by parent or surrogate.
4. Individuals must be served in the least restrictive environment that reinforces normative behavior and expectations and which avoid stigmatizing the individual.	4. See technical note 8.1.a., page 6.
5. Confidentiality of individual information must be protected by program personnel and review teams.	5. Both the Lanterman legislation for care providers (Welfare and Institutions Code, Sections 4500-4510) and PL 94142 for educators (The Buckley Amendment) require strict adherance to regulations protecting the privacy of the individuals in your facility. You should he familiar with these regulations.
6. There should/shall be one complete record maintained for each individual, conveniently located for easy reference to direct service staff and access by parents and official monitoring personnel.	
7. The record-keeping procedure for the specific aversive behavior intervention should be sufficient to allow for day-to-day monitoring of behavior to develop appropriate summary graphs.	7. It is not necessary to save/accumulate reems of raw data but data should he summarized in accordance with technical note 3e above. Care should he taken to see that the data is taken on behaviors which are being positively reinforced often enough and in a form compatible with the ABI data to enable you to see interrelationships.

STANDARDS	TECHNICAL NOTES
8. When a program has only used mild aversive or nonaversive procedures and an individual seems to need a more intensive, more restrictive intervention, personnel in the program must seek collaboration and those services for the individual from other agencies and professionals to assure continued placement in this less restrictive environment.	8. Client/student rights are not served by automatically placing persons with difficult behavior problems in the "behavior modification program" in your facility. The concept of LRA and Right to Treatment require that, to the maximum extent possible, treatment interventions take place in the environment in which the behaviors occur. Similarly, the principles of learning tell us that, since many persons in need of developmental services have problems generalizing learning, it is best to teach new behavior patterns in the environment in which you want them to ultimately occur.

B. MULTIDISCIPLINARY DECISION-MAKING PROCESS

STANDARDS

1. Before any aversive behavior intervention is used, the following should/shall be considered and documented in developing a plan.

   a. The environment where the behavior change is programmed in order to avoid stigma and in order to support and reinforce the desired behavior.

TECHNICAL NOTES

a. Any specific procedures for strengthening or weakening behavior which are discussed here can be maximally effective in contributing to the client's development only in the context of a humane, stimulating, and normalizing environment. The effects of the specific procedures are inseparable from the total physical and social environment in which the client spends most of her/his time. The first step in any program, then, is to ensure that clients have the continuing opportunity to participate in their environment, to become engaged in activities, and to talk to staff and other clients. Living units and other places where clients spend their time must have available materials and structured activities, and staff members must be trained to engage continuously in social interactions with clients. Such an environment would not only prevent the loss (due to nonuse) of skills clients have but would contribute heavily to the practice and elaboration of any skills a client might learn in specific therapy sessions. Ideally, any skills a client learns in educational programs away from the living unit would be further supported and elaborated when she/he returns to the living unit, and new skills should be acquired in the context of daily activities on the living unit.

Stigmatic and Environmental Considerations

Aversive procedures in general, and in fact, many positive procedures may be abused in subtle ways if the intent and effect is to impose a social stigma on the client or if they take the place of a more

socially adequate environment. The review process may decide that treatment programs which are allowed in these guidelines violate the spirit of these guidelines in this particular way. They may also decide in some cases that a mild social stigma of limited degree may be therapeutic.

In general, procedures may be considered to add to social stigma whenever they produce scorn or ridicule from peers or the public which is beyond the scorn or ridicule produced by the behavior which the therapist is seeking to eliminate. In cases such as these the normalization principle has been clearly violated, and they should not be allowed. The interdisciplinary team must consider this factor before approval of all programs, and the review process must also weigh this factor. In addition, the team and review process shall consider any long-term effects upon the client's self-image or self-respect.

Other more general social considerations should be taken when inappropriate behaviors occur. The environment in which the client spends his time and exhibits the problem behaviors must be examined before aversive treatments are employed. The setting should be surveyed at regular intervals throughout the day for several days and a count made of the clients in that setting who are actively engaged in watching or interacting with materials, activities, or people at that moment in time and whether the client in question is so engaged. It should also be noted which staff members are giving attention to the clients or to other activities such as paperwork. Such "spot checks", if done frequently and regularly (e.g.,

every half hour) throughout the day for several days, will provide a workable diagnosis of the environment in which the problem behaviors are occurring and suggest the remedial procedures which must be employed before more direct measures are taken. If most of the students in your program are not found to be engaged for some parts of the day, more engaging materials and activities must be planned and provided for those times. If most clients are engaged throughout the day but the client in question is not, special materials and activities more appropriate to his interest and skill level should be sought or he should be transferred to another environment where appropriate materials and activities are available. For example, in a living arrangement, if staff members are not giving their time to the clients but are busy with housekeeping chores, more staff should be provided and/or more efficient housekeeping routines instituted. If staff members are giving their time to neither clients nor housekeeping, training and supervision procedures should be reevaluated and strengthened.

Once a client is appropriately engaged in activities throughout the day and staff members are devoting a substantial portion of their time to the clients, most behavior problems which occur can be handled and severe behavior problems can be prevented by skillful staff members trained in the procedures of differential reinforcement and extinction. Wherever possible, reinforcement systems should be developed to reward staff for using effective rewards. Pay-offs for using aversive programs are generally intrinsic to the treatment situation.

STANDARDS	TECHNICAL NOTES
	In order to prevent abuse, any procedure for weakening behavior can only be implemented when there is evidence that a client actually has behaved inappropriately. Usually this requires that a staff member actually witness the inappropriate behavior. If a particular client is consistently reported as behaving inappropriately only by one particular staff member, then an inquiry should be instigated. It may be that the staff member is either promoting the behavior or enforcing more rigid standards than other staff members.
b. The relative effectiveness of different procedures from which a choice is made.	b. Behavioral procedures vary in their effectiveness as they are applied to different behaviors. To the extent possible these guidelines have taken into account the data that are available concerning this relative effectiveness. For example, severely self-injurious behavior that can result in permanent injury or even death requires the most effective intervention possible even though the intervention may be more aversive or restrictive than other procedures which may be less effective. On the other hand the effectiveness of a procedure is not an absolute argument for its use.
c. The undesirable long- and short-term side effects that may be associated with a procedure for the individual.	c. Another clinical contraindication for a procedure may be its side effects. For example, studies have shown that severely restrictive aversive procedures (Ulrich and Azrin, 1962) may have the side effect of eliciting aggressive behavior. Given this, it should be determined whether resulting side effects will outweigh the potential benefits or success of the aversive procedure.

STANDARDS	TECHNICAL NOTES
d. The condition(s) under which a specific procedure is contraindicated.	d. There are conditions under which a particular behavioral procedure is clinically contraindicated. In some cases a given procedure would not be expected to be effective. For example, extinction, while a useful procedure for a wide variety of behaviors, has some limitations. The stereotypic rocking of an autistic client is most likely maintained by factors other than the rewarding attention he gets from others in his environment. In such a case ignoring the behavior would be an intervention procedure clinically contraindicated because of its predictable ineffectiveness. Similarly, extinction (including, sometimes ignoring) also tends to escalate behaviors before they decrease. Therefore, it would be contraindicated when escalation of the behavior in question might cause a dangerous situation.
e. The efficiency of the specific procedure chosen in terms of need for duration, frequency, and staff requirements.	e. A further clinical consideration is the relative efficiency of a given procedure. Procedures may be equally effective in bringing about a desired behavior change. There may, however, be a difference in their efficiency. For example, shaping (rewarding approximations to the desired behavior) may be just as effective in teaching a client to sit in his seat during dinner time as instructional control, but it is unlikely that it would be equally efficient in terms of the time and effort required. Finally, we have tried to reflect a consideration for the clinical benefits a given procedure may have as applied to a particular behavior. If any therapeutic procedures are to be employed, they must be for the benefit of the client and not simply for the convenience of the facility. (See technical note 5.)

STANDARDS	TECHNICAL NOTES
f. The social, behavioral, and/or status benefits that can be expected for the individual.	
2. Prior to the initiation of the use of ABI, a thorough assessment of the individual utilizing a multidisciplinary process must be completed in the following areas:	2. Obviously, this kind of assessment information will be developed on all the individuals in your program routinely and at least annually. In terms of the ABI, however, particular attention must be paid to the conditions under which the problem behavior occurs. For example, in order to intervene in a tantrum behavior you would want to know if it occurs when a student has difficulty with a particular task. In order to get that information you would have to know how this particular student learns best (learning style and level) and try to remedy that learning situation before you tackle the tantrums which are caused by it.
a. Social interaction.	
b. Communication.	
c. Physical development and health.	
d. Cognitive and adaptive status.	
e. Learning style and level.	
f. Target behavior identification which includes an evaluation of the antecedents, analysis of the target behavior, and the conditions which contribute to the maintenance of the target behavior.	f. Most problem behaviors, even the most bizarre and severe, occur because they produce results for the client. Clients labeled developmentally disabled and mentally disabled often engage in maladaptive behavior because they produce immediate and predictable responses from other clients and staff members. Indeed, in a barren environment with an inattentive (or insufficient) staff, such problem behaviors may be the only means clients

SUGGESTED INTERACTIONAL STYLE...
NOT ABSOLUTE BUT EMPHASIZES ATTENTION TO POSITIVE BEHAVIORS FIRST. REFERS TO GENERAL ENVIRONMENTAL PREPARATION PRIOR TO ANY INTERVENTIONS.

have of obtaining physical and social stimulation. Such an environment is in violation of a client's right to an adequate environment which will support his development.

To avoid this infringement of basic human rights, staff must be trained to provide materials, organize activities, and promote and facilitate appropriate and more skillful behaviors while the client is engaged. The staff must be trained to provide frequent attention, sincere praise, and assistance for all appropriate forms of interaction with materials and other people and to ignore inappropriate behaviors so as not to inadvertently strengthen them (Williams, 1959; Wolf, Birnbrauer, Williams, and Lawler, 1965).

Whenever human interaction occurs, some behaviors are reinforced while other are ignored. In their dealings with clients, therefore, direct care staff are delivering consequences for behavior. Thus, staff members must be taught to completely ignore any instances of inappropriate behavior and to heavily reward each instance of appropriate behavior. The provision of a high level of interaction among staff members and clients, where these procedures are skillfully used, may be especially effective in preventing the occurrence of such maladaptive behaviors as aggression or self-stimulation. Such interaction is essential for the development of complex behaviors such as language which requires many instances of interaction. Staff members must understand their ongoing responsibility for building such complex behaviors rather than assuming that they will be developed in short training sessions. Furthermore, staff must be alerted to the fact that responding to primitive forms of a behavior when the client is capable of more complex forms only delays development.

STANDARDS	TECHNICAL NOTES
	The extinction of inappropriate behavior and concurrent reinforcement of appropriate behavior is difficult to use after a client has developed a high rate of maladaptive behavior. If such is the case, staff members should be aware that when a client is ignored for a particular behavior, he will temporarily engage in more of that behavior. In addition, if the behavior is being supported by the social group rather than by staff members, it may mean that the peer group must be taught how to interact more appropriately with the client. This aspect is particularly important with higher functioning, more age appropriate, and more verbal clients. These characteristics make extinction and concurrent reinforcement much more suitable as preventive rather than remedial measures. These procedures would not usually be the only ones recommended if an individual's behavior caused harm to himself/herself or others or greatly disrupted his environment.
3. When situations exist where an individual is causing serious physical harm to self or others or serious property destruction, the multidisciplinary process can be initiated at the same time as the ABI but must be completed as soon as possible.	3. It is essential to remember that though one might have to intervene to save a life or protect property, that intervention does not necessarily become treatment even if it is effective. For example, physically pulling one individual away from a weaker person may be an urgent necessity; however, if the behavior continues to occur, you must look at all the relevant variables and attempt to present or control the behavior as part of a planned treatment process. Similarly, new persons entering a program present unique problems.

A one- to two-week period is suggested for new admissions to a program in order to allow the client to adjust to his/her new surroundings. Treatment should be offered within two weeks. This initial period should be utilized by staff to (a) verify recommendations of previous programs and (b) suggest further areas which may be indicated for interventions. Before this period terminates, the interdisciplinary team must meet to determine long-term goals which are appropriate for this client.

Consequent to baseline observations, the interdisciplinary team should plan the immediate short-term goals in detail. The order of intervention on target behaviors should be specified, along with the precise interventions to be employed. In addition, the staff to be carrying out the intervention must be named, and the precise system of measurement must be delineated along with specific criteria for goal attainment. Finally, the team must determine the date for the next session in which the client's case will be updated. This date must not exceed one month from the date of the present meeting. The client's progress may be reviewed prior to this date if the treatment fails or if some other crisis warrants immediate attention. Decisions made at this time with respect to a particular intervention are subject to two restrictions: (a) No change should be made prior to adequate observation. In cases of imminent danger to the client or others, such observation should be kept to a necessary minimum. (b) The team must be presented with a written review of all data relevant to this decision. They should also be afforded an opportunity for direct observation if required.

C. CONTINUUM OF BEHAVIORAL INTERVENTIONS

STANDARDS	TECHNICAL NOTES
1. The members of the multidisciplinary process should/ shall document the rationale for not using less restrictive alternatives for each individual for which aversive procedures are planned. All interventions exist on a continuum and must be explicitly addressed and documented in the decision process.	1. Alternatives to the Use of Aversive Therapy. The elimination of undesired behaviors does not necessarily require the use of aversive procedures. A number of positive approaches may be effective under certain conditions. A brief description of some of the alternatives are provided as follows: Instructional Control Definition Instructional control is the delivery of information as to the correctness/appropriateness or inappropriateness of behavior. Such instructions may be effected through manual guidance of the client through the correct response, (a prompt) or verbal statement such as "yes", "no", "correct", or "wrong". Instructional control is not considered as restrictive. Treatment Considerations Instructional control is established through the differential reinforcement of those responses that are in compliance with the verbal instruction presented. What is taught is the contingency rule: "Do as I say and you will be rewarded." An instruction is given over a series of trails until the client complies at some specified correct percentage. At that point a second instruction is introduced. This procedure is continued until compliance is obtained to a number of novel instructions on the first trial. Many clients are already under instructional control, and it is not necessary to

establish it, only to use it. In the classroom using discrete trial methods (Donnellan-Walsh, et al., 1976), autistic children have been taught to follow the instructions of the teacher. Some initial instructions include "sit down", "sit still", "hands down", "look at me", "touch -- this or that body part", etc. Once generalized instructional control has been established, it is much easier to control undesired behaviors.

Differential Reinforcement of Competing Behavior

Definition

The reinforcement of those behaviors that cannot be physically performed with the undesired response in intensity, duration, or topography.

Examples:

The procedures require the differential reinforcement of those behaviors that are incompatible with the undesired behavior. Some examples of incompatible behaviors are:

Undesired Behavior	Incompatible Behavior
a. Out of seat	a. In seat
b. Throwing objects	b. Writing or reading
c. Pushing in line	c. Standing with arms at sides
d. Fighting on playground	d. Playing on playground

Differential Reinforcement of Low Rates of Responding (DRL)

Definition

DRL involves the reinforcement of the undesired behavior only if at least a specified period of time has elapsed since the last episode or only if fewer than a specified number of the undesired behavior occurred during a preceding interval of time.

Examples:

There are two ways to implement a DRL procedure. One way is to deliver the reinforcement contingent upon the occurrence of the undesired behavior only if a certain minimal period of time has elapsed since its last occurrence. This should increase the proportion of intervals of that size and, therefore, lower the frequency of the undesired behavior. The interval can then be extended to further decrease the rate of the behavior.

The second kind of DRL procedure might involve delivering the reward every hour according to a specified schedule if there were, for example, nine episodes or less during the preceding hour. This would also act to decrease the frequency of the undesired response.

Differential Reinforcement of Other Behavior (DRO)

Definition

DRO is the reward after a specified period in which the undesired behavior is absent.

As with DRL, there are two ways to implement this procedure. In the first case a period of time is specified and if that period passes without any occurrences of the undesired behavior, then the reward is delivered and a new time period starts. If the behavior occurs, no reward is delivered and the "timer" is reset. One disadvantage of this procedure is that behavior tends to occur just after the reward is delivered. A way to avoid this is to establish a schedule of reward which is progressively increased with each consecutive period of no responding.

A second form of DRO is to deliver the reward on a preset schedule as long as the target behavior has not occurred during the previous specified period. So, for example, reward would be delivered every hour by the clock as long as the behavior had not occurred during the previous hour. This differs from the previous DRO schedule in that the timer is not reset. Progressive schedules of reward are also effective with this form of DRO.

Additive Procedures

Additive procedures are the combination of two or more procedures in order to reduce or eliminate an undesired behavior.

Many times any given procedure is not effective by itself in reducing behavior to the desired level although it may be effective in reducing it somewhat. In these cases the addition of another procedure may be more effective than the substitution of another procedure. A given procedure need not be totally effective but may contribute, along with other procedures, to a solution of the behavioral problem.

LEAST RESTRICTIVE REFERS TO PROCEDURE USED NOT OUTCOME EXPECTED!

These notes will be concerned with three further considerations in the use of aversive procedures. First, insurance must be taken that the least restrictive procedure is applied. Second, limits must be placed upon the most restrictive procedure used for a particular behavior. These limits should be geared to the seriousness of the behavior and how much the presence of that behavior restricts efforts at normalization. Third, attempts must be made to limit the potential for abuse of specific treatments. These considerations will be effected by a suggested ordering of aversive procedures by their level of restrictiveness and maladaptive behaviors by their seriousness. Division of each into the following four nonexhaustive categories will serve as a basis for this discussion.

The following represents one way of partial listing four categories of aversive procedures. It is intended to serve as a starting point for decisions of interdisciplinary teams and review teams to augment and work with. The categories are rank ordered in our opinion in terms of increasing restrictiveness or intrusiveness but, of course, ultimately such intrusiveness is a function of the effect on the individual.

Examples of Category 1: Contingent observation, extinction procedures, withdrawal of social contact, negative reinforcement.

Examples of Category 2: Educational fines, exclusion timeout.

Examples of Category 3: Contingent mini-meals, seclusion timeout, overcorrection, harmless bad tasting or smelling substances.

Examples of Category 4: Contingent slapping, response contingent electrical stimulation.

The definition and treatment considerations of some of these procedures follows.

Contingent Observation

Definition

Contingent observation is the removal of a client from participation in an activity for a short period of time after he has just misbehaved.

Treatment Considerations

Contingent observation combines elements of exclusion timeout (Wolf, Risley, and Mees, 1964) and modeling (Bandura, 1969) and assumes a program of well planned activities for the clients. A client who is doing something inappropriate is asked to step away from the activity for a few moments, sit in a chair nearby, and watch the appropriate behavior of other clients. The staff member deliberately attends to other clients who are appropriately behaving in ways the client should observe. The client rejoins the activity after a few moments of observation and after indicating that he intends to behave appropriately. After returning to the activity, he receives feedback from the staff member for appropriate behavior. Clients who leave the chair or refuse to sit and watch either because the ongoing activities distract them or because they are upset are taken to another area where they can practice sitting or calm down before they return to the chair to watch the others.

When contingent observation is used in a setting where the ongoing activity is engaging and reinforcing for a client, the observation period need only be long enough to offset the possible reinforcing effect of the educational instructions -- a few seconds' removal from a highly engaging activity (e.g., eating), a minute's removal from an adult-structured, well organized activity, several minutes' removal from a passively supervised play time with other clients and toys, up to 15 minutes' removal from a situation with opportunities only for a client-initiated interaction with staff, other clients, or materials. In all cases the observation period should continue until the client is quietly watching the ongoing activities and can indicate an agreement to behave appropriately. Beyond this duration and perhaps an additional 30 seconds of quiet, increasing the length of the observation period is unlikely to increase the effectiveness of the procedure. Accordingly, a note should be made in the client's chart whenever he sits in the observation chair longer than 15 minutes before he indicates he is ready to again participate appropriately. Similarly, a note should be made whenever a client must be sent to another area to practice sitting or to calm down, and the time he is sent and returns should be recorded. If the client must be sent to another area, that area must be within visual and hearing range of a staff member at all times. If the door between that area and the ongoing activity area must be shut or latched, that fact should be noted, and a staff member must be stationed at the door so as to easily see and hear the client at all times.

Any 5 such notes (e.g., longer than 15 minutes in the chair, being sent to another area, and door having to be shut between areas) in any week would require that the interdisciplinary team review his program to determine if adequately engaging activities are being provided for him or if another procedure is needed to correct his problem behavior.

Extinction

Definition

Extinction is the systematic elimination of potential rewards for a particular behavior. Such elimination is often accomplished by staff pretending a behavior did not occur (ignoring).

Treatment Considerations

See technical note 2f, Multidisciplinary Process.

Withdrawal of Social Contact

Definition

Withdrawal of social contact is the termination of an interaction with a client immediately after the client demonstrates an inappropriate behavior. Typically, the interaction resumes shortly after the client ceases the inappropriate behavior.

Treatment Considerations

Treatment considerations for withdrawal of social contact are the same as those for extinction (Section 8.5.2).

Negative Reinforcement

Definition

Negative reinforcement is the attempt to increase the frequency of a desired behavior by allowing that behavior to terminate an aversive stimulus or event. These guidelines

STANDARDS | TECHNICAL NOTES

note does not say that

note refers to client's own provision of an aversive event not his behavior

is [illegible] state of discomfort? [illegible] or client?

will allow negative reinforcement only with client-initiated aversive events or stimuli.

Treatment Considerations

An example of negative reinforcement is the client avoiding the experience of wet pants by using the toilet properly or escaping wet pants by putting on another pair of pants. In some cases this procedure is not effective in increasing a desired response. This type of program should be reviewed frequently and discontinued if proven ineffective after a reasonable period of time.

Definitions and Examples of Mildly Restrictive Aversive Procedures (Category 2)

Educational Fines

Definitions

Token rewards are articles given to or indications made about a client which can be exchanged at some future time for a desired object or activity.

Educational fines are the loss of token rewards consequent to predetermined inappropriate behavior.

Each fine must be accompanied by a teaching episode which includes a description of the inappropriate behavior, the amount of the fine, instruction on the appropriate form of the behavior, and the opportunity for the client immediately to "earn back" a portion of the fine for practicing the appropriate behavior.

Treatment Considerations

If the client displays the appropriate behavior, he is praised, a portion of the fine is returned to him, and the episode ends. If the client refuses to practice the appropriate behavior, the episode ends without a return of a portion of the fine. If the client exhibits argumentative, abusive, or other inappropriate behavior when fined, he may receive an additional educational fine. However, the client should receive an immediate opportunity to display appropriate behavior and thereby reearn a portion of the second fine (and then the first fine); then the episode should be terminated regardless of the client's behavior. Fines should never result in the client owing more than he has.

The educational fine procedure should be subject to the following restrictions. In no case should a fine be greater than approximately ten percent of a client's average daily earning (and he should have the opportunity to earn back half or more of each fine immediately for practicing appropriate behavior).

In addition to the normal token records, an explicit note should be made in the client's chart whenever a client does not earn back a portion of a fine or whenever he loses half or more of his daily token earnings in fines. Any five such notes in any week should require a review of the client's program by the treatment team to determine if there are adequate opportunities to earn tokens and an adequate variety of things to purchase for the client or if another procedure is needed to handle his problem behaviors.

Educational fines will be more effective when the client is frequently able to buy a variety of items with his tokens. The fewer the opportunities to buy and the more restricted the selection of items and privileges available, the less effective educational fines will be in reducing inappropriate behavior and the more often inappropriate behavior will occur during fining episodes. If a client is regularly purchasing a variety of items and privileges with his tokens, educational fines will be effective in reducing inappropriate behavior and he will be eager to earn back a portion of the fine by practicing appropriate behavior.

Fines

Definitions

Fines are a loss of token rewards without a description of the inappropriate behavior or the opportunity to earn back a portion of the fine for responding appropriately.

Treatment Considerations

The educational components of these procedures should be discontinued only as a prescription for particular clients and only after review by the supervisor/consultant.

In no case should a fine be greater than ten percent of a client's average daily earning. Explicit note should be made in the client's chart as per educational fines (Section 8.6.1).

Exclusion Timeout

Definition

Exclusion timeout is contingent observation without the educational component. It involves simply removing a client from an activity to another area in the environment for a short period of time without talking to the client or requiring him to watch or respond appropriately.

Treatment Considerations

The same treatment considerations apply as for contingent observation. This program should require the authorization of the supervisor/consultant only as treatment for particular clients.

Definitions and Examples of Moderately Restrictive Aversive Procedures (Category 3)

Contingent Mini-Meals

Definition

Contingent mini-meals occur when the regular diet is broken into five or more smaller units (which can be as small as a bite). Each unit is given to the client after a particular target behavior occurs.

Treatment Considerations

The use of food or liquids as reinforcers is sometimes helpful when a client is not amenable to the intrinsic or social

reinforcers in his environment (Section 3). Although some foods, such as sweets, are often powerful reinforcers regardless of the time of the client's last meal, a period of deprivation can contribute to the reinforcing effectiveness of food and may be necessary to make it effective for a client.

Since food deprivation involves an ethical and legal consideration concerning depriving a client of basic rights, certain safeguards must be established for its use. Therefore, no deprivation should occur which results in the intake of less than the normal amount of food for that client. When less drastic alternative procedures have been ineffectual, such deprivation may be deemed necessary for a particular client.

In cases in which appropriate self-feeding behavior is deficient, food supplements should be used to maintain body weight.

It must be emphasized that dividing the daily diet into mini-meals is never to be used as a means of weakening behavior but rather in the context of increasing the motivation of a client to participate in a training program.

Seclusion Timeout

Definition

Seclusion timeout is isolation of a client in a locked room. (Seclusion timeout should be distinguished from exclusion timeout which simply involves removing the client to another area of his environment.)

Additional Restrictions

Under some conditions (Section 8.4) the interdisciplinary team may prescribe the use of seclusion timeout in a specially constructed locked room for a special behavior problem. This prescription should be immediately implemented on an interim basis. The seclusion timeout room should be free of objects or fixtures that can be broken or used to inflict injury. A staff member must be explicitly assigned to the area of the timeout room for continuous monitoring of the client. The room must have a window or opening permitting visual monitoring of all portions of the room. The room must be large enough to allow the client to stand and stretch his/her arms. If the time extends to one hour, one of the senior persons on his prescriptive program committee must be immediately called and be in continuous attendance until the end of the episode. Records should be made of the time the client entered the room and the time he left it. Notes should be made of the circumstances surrounding the episode and the client's behavior before, during, and after each timeout episode.

When a prescription for seclusion timeout is written, the client's program must be immediately and thoroughly examined. The procedures described above for evaluating the adequacy of his living environment in engaging his interest and in providing differential social reinforcement for his behavior should be implemented. Transfer to another living environment where the staff and residents are less endangered by his problem behavior should be considered.

Overcorrection

Definition

Overcorrection is when the client is taught to assume responsibility for the disruption to the environment caused by his inappropriate behavior by restoring the environment to better than its original condition (restitution) and by intensively practicing appropriate behavior (positive practice).

Treatment Considerations

Overcorrection, a technique developed by Foxx and Azrin (1973) is most appropriate in situations where there is no program of planned activities from which clients can be removed to watch. The overcorrection procedure has been used to reduce self-stimulatory behavior as well as aggressive and disruptive behavior.

This procedure is effective only when there exists a large amount of interaction which is rewarding to the client. The client's behavior is not only interrupted by overcorrection, but he must expend a great deal of effort in restitution and positive practice. The avoidance of the effort provides the incentive to behave more appropriately in the future.

Twenty to 30 minutes is the recommended length of each episode (with the exception of self-stimulatory behaviors where 5 minutes is the recommended length). However, empirical determination of this interval is advised. In addition to a regular record of each overcorrection episode, a special note should be made whenever a client actively resists manual guidance during the procedure. Five such notes in any week

should require a review of the client's program by the interdisciplinary team to determine if overcorrection may be reinforcing in contrast to an inadequately engaging environment and whether another procedure might be needed to deal with the client's problem behavior.

Force only sufficient enough to ensure implementation of overcorrection should be used. Contact should only be applied to arms, legs, and/or head. The client should be given the opportunity to comply without force. Such force or contact should be frequently reduced to test the client's willingness to comply.

Harmless Bad Smells or Tastes

Definition

This procedure involves the presentation of a bad smell or taste to the client after the occurrence of the target behavior. These substances must not be harmful to the client in any way.

Severely Restrictive Aversive Procedures (Category 4)

Definition

A severely restrictive aversive procedure is one which involves the use of any event which causes a physical sensation of pain or extreme discomfort (not subsumed under any of the above treatments). Only two acceptable forms of extremely aversive procedures are allowed (subject to limitations in) -- either slapping or electric shock -- as a consequence of each instance of maladaptive behavior (see technical note). These punishers can be administered

alternatives may be explored by Rees Lewis/Norm Right

when the client is totally out of restraints (Lovaas and Simmons, 1969; Corte, Wolf, and Locke, 1971) or as the client is being slowly eased out of restraint (Tate and Baroff, 1966). Immediately after (e.g., within three seconds) of a maladaptive response, the therapist should use a loud "no!". The client may be given an opportunity to cease the maladaptive behavior at this point, or punishment may follow immediately. If the client is provided with the opportunity to avoid electric shock by inhibiting subsequent maladaptive responses, shock should be withheld if the maladaptive response is inhibited for specified amounts of time and made contingent within two seconds after the next immediate maladaptive response. In general, if there is no observable reduction in rate by the fifth application of this aversive stimulation, the procedure should be reviewed and possibly discontinued.

The effects of this treatment may not generalize to other people and environments (Frankel and Simmons, 1976; Lovaas and Simmons, 1969). If not, then it must be carried over to these new situations and people. The client must be punished in all environments with all contact persons present (punishment should proceed to new situations and people on an individual basis). Reward programs must always coexist with these procedures. Punishment has traditionally been avoided because of suspected undesirable side effects (Lichstein and Schreibman, 1976). Experimental data have shown these side effects to sometimes be therapeutically advantageous; for instance, increased alertness and social behavior. However, this may not be true for all clients so that potential undesirable side effects should be carefully monitored.

STANDARDS

2. The interpretation of behavior, as acceptable or nonacceptable, must take into account the social, religious, and ethnic values of the individual, the family, and the community and these should take precedence.

TECHNICAL NOTES

2. The question of how one decides a behavior is unacceptable is a complicated one and has serious implications from a legal, ethical, as well as procedural viewpoint. We will attempt in these notes to highlight some of these issues as they relate to multidisciplinary team decision-making:

The Constitution and Bill of Rights guarantee to every citizen the right to be left alone, that is free from government interference unless there is a compelling state interest to intervene in a person's life. Courts are particularly sensitive to interventions which are used as a result of decisions which are not primarily concerned with the rights of the individuals. In Wyatt v. Stickney the federal court held that: "Residents (in this case of a state institution) could not be subjected to behavior modification procedures when the aim of the procedure was merely institutional convenience." Obviously, therefore, you must look at a behavior you wish to change in terms of its value to the individual as well as the problem it presents to you. If, for example, it is more convenient for your facility to have individuals sitting quietly for one-half hour before meals with no activities, yet some prefer to wander about, you should be most cautious about using an aversive intervention to bring about "good sitting behavior".

There are some circumstances in which a mild punishment to bring about "good sitting behavior" <u>might</u> be justified from a legal as well as an ethical point of view; perhaps to enable a student to ride safely in a car. In order to deal with the ethics of this matter you should at least be aware that behaviors do not fit into categories of "acceptable" and "non-acceptable". Acceptability or desirability fall on a continuum and behavior has degrees of desirability. Where a given

behavior falls on that continuum is dependent upon the standard by which the behavior is judged. In the above example, sitting quietly in a moving vehicle would be judging the behavior from a standard of "life"; i.e., the behavior could severely effect the quality or quantity of the individual's life and those around him. Quiet sitting for an extended period of time before meals is judging a behavior in terms of the needs of the facility; the behavior may have little value to the individual. Practitioners should understand the underlying concepts which affect their decision-making process because they have direct bearing at a minimum on the kinds of procedures one might use to change a behavior. (La Vigna and Donnellan-Walsh, 1976.)

One standard by which one could judge a given behavior is the impact of that behavior on the normalization possibilities for the person; e.g., an opportunity to learn and live in a less restrictive environment. The following represents a partial list of maladaptive behaviors categorized in our opinion according to their potential impact on normalization:

Examples of Category A:

Incorrect - Client is incorrect or fails to respond to demands or questions posed by the therapist.

Persistent incorrect - Client is incorrect significantly more often than expected by chance or generally refuses to respond to questions or comply with demands of therapist.

Inattention - Client looks in direction other than required by therapist or gives indication of disregard of instruction.

Out of seat/evasion - Client physically evades therapist when sought or required to be within range.

Examples of Category B:

Public masturbation - Repetitive acts performed in public, specifically involving the genitals.

Bizarre speech - Verbalizations which are noncommunicative in nature and contextually inappropriate.

Sterotypic behavior - Repetitive acts having no obvious goal.

Tantrums - Client becomes agitated, hyperventilates, screams, or cries.

Spitting - Directed at people.

Throwing objects - When not directed specifically at people. Also includes deliberate destruction of objects.

Examples of Category C:

Aggression/adult - Hitting, pushing, scratching, hair pulling, or biting, or attempts to do so directed exclusively at adults.

Aggression/peers - Hitting, pushing, scratching, hair pulling, or biting other clients.

Self-induced seizures - Clinically verified seizure activity precipitated by flicking hands before the eyes, blinking (not itself part of the seizure), and hyperventilation. These precursors should have been demonstrated to be followed by seizures during baseline.

Self-induced vomiting/rumination - An overt act (e.g., stomach tension, reaching down throat) precipitates vomiting.

Pica - Eating nonedibles or debris.

Mild self-injury - Self-injury not serious enough to be included in Category D.

Examples of Category D:

Dangerous destructiveness - Throwing objects at people which may cause injury or destruction of objects such as electrical equipment while functioning which may cause injury to self.

Violent aggression - Severe enough to cause life-threatening or harmful consequences to others.

Severe self-injury - Performed with either sufficient intensity to result in serious injury or death if left unattended or with sufficient rate such that a significant amount of the client's time is occupied with this behavior.

Restrictiveness as a Function of the Inappropriateness of a Behavior

As suggested, the inappropriateness of a behavior has ethical implications for the kinds of intervention procedures which might be used. For example, the self-injurious behavior of a child with the problem of autism might, in some cases, justify the use of shock to deliver contingent punishment. We would maintain, however, that the cursing by an adolescent would never justify such an intervention procedure. Behaviors which are relatively mildly undesirable or inappropriate justify

no aversive procedure should be made between various behavior reduction components.

less extreme and punitive intervention procedures. The reverse, however, does not necessarily hold. Extremely undesirable behaviors do not necessarily justify an aversive procedure. Considerations of immediacy and urgency notwithstanding, if nonpunitive procedures work for one set of behaviors (the mildly unacceptable), then they should be effective for another set (the highly unacceptable). Given two or more equally effective procedures from which to choose to control an undesirable behavior, then the least restrictive procedure should be used.

The following represents one attempt at justifying different levels of restrictiveness as a function of the undesirability of the behavior to be modified, assuming that all the other standards in this document have been met:

STANDARDS | TECHNICAL NOTES

1 possible ordering, not meant to be conclusive. Peer review etc should consider this "model"

T.N. represent approach in which facilities should go thru in applying the stds. & the analogous decisions process pursued. T.N. should not be more than model. Process must include

Examples of Aversive Procedures

Category 1:

Extinction - except when used as a part of a differential reinforcement program.
Withdrawal of social contact.
Contingent observation.
Negative reinforcement (client-initiated).

Category 2:

Educational fines.
Fines.
Exclusion timeout.

Category 3:

Contingent meals.
Seclusion timeout.
Overcorrection.
Harmless bad smells or tastes.

Category 4:

Contingent slapping.
Response contingent electrical stimulation.

Examples of Maladaptive Behaviors

Category A:

Incorrect.
Persistent incorrect.
Inattention.
Out of seat/elopement.

Category B:

Public masturbation.
Bizarre speech.
Stereotype behavior.
Tantrums.

Category C:

Adult aggression.
Peer aggression.
Self-induced seizures.
Self-induced vomiting/rumination.
Pica.
Mild self-injury.

Category D:

Dangerous destructiveness.
Violent aggression.
Severe self-injury.

Exceptions?

In order to meet the standards to which these notes apply, ordinarily one must arrange for the following:

a. Prior to the application of any member of Category 1, the client must have been subjected to programs of positive reinforcement contingent upon appropriate behavior which have been detailed in the client's chart.

   Aversive procedures in this category may be used to control behavior of any severity.

b. Prior to the implementation of aversive programs of Category 2, a token economy and/or differential reinforcement programs should have been attempted, and programs in Category 1 should have been attempted which have been detailed in the client's chart. Aversive procedures in this category could be used to control behavior from any category subject to restrictions herein.

c. Prior to the implementation of programs of aversives in Categories 2, 3, or 4, the client's parents, legal guardian, or surrogate must have been given notice and granted their informed consent to the use of these procedures in writing.

d. It is appropriate to design programs for a specific precursor of a response which appears earlier in a behavioral chain only if baseline observations have established that it is usually followed by a maladaptive behavior and only if this earlier response itself is maladaptive.

Categories 3-4

Remember the principle of least restrictive alternative and the need for greater due process as you intervene more heavily into another person's life.

Aversive programs in Categories 3 and 4 are usually considered highly aversive by the client, are easily subject to abuse, and have the additional concern of social stigma regardless of their procedural value.

In order to meet these standards the protections, evaluation, and review processes both within your facility and outside of it must be stringent.

At a minimum, we would state:

e. Before implementing aversive programs in Category 3, interventions from Categories 1 and 2 and differential reinforcement programs and/or token economy should have been attempted.

3. Specific baseline observations and recording of the target behavior should/shall be taken in sufficient detail to provide an objective measure of the undesired response before intervention and to provide relevant information to carry out a functional analysis before an aversive intervention is used. Systematic baseline observations are typically omitted, however, when an undesired target behavior is life-threatening, or threatens the physical well-being of others, or when serious property destruction has occurred.

3. Baseline observations can be taken in one or more situations, in one of at least three different ways. (a) The observer may be present in the situation, but ignoring target behaviors (the use of "ignore" may itself be considered an intervention). (b) The observer may simply record the target behavior and treat the client as was done previously (in the case of clients who have been in the facility for at least three weeks prior to selection of the particular target behavior). (c) The observer may not be present in the situation with the client, but covertly observing (e.g., with the use of videotape or one-way mirror). Baseline observation is

4. Individuals with maladaptive or problem behaviors that are to be modified will have a written program plan which includes provisions: (a) to teach the individual the circumstances under which the behaviors can be exhibited appropriately to shape the behaviors into more appropriate expressions; or (b) to replace the behaviors with those that are adaptive and appropriate.

5. Each plan (program) to modify behavior for an individual will specify in writing:

   a. The targeted behavior stated in objective and quantifiable terms.

typically omitted when an undesirable target behavior is life-threatening or threatens the well-being of others. These cases may be either severe self-injury, such as head banging of severe intensity, or violent aggression which risks the well-being of other clients.

4. For example, it is usually simpler, and of course more legally and ethically sound, to teach someone the appropriate setting where masturbation or self-stimulation can occur than to attempt the near impossible task of eliminating these behaviors.

   a. Objective criteria should be employed in the definition and measurement of all target behavior. In the presentation of guidelines for objectification, it is necessary to divide target behavior according to the types of goals that foster them. Programs employing aversive procedures must demonstrate that these interventions occur within an individualized program that has both short- and long-term goals and are the least restrictive alternatives available.

   b. Reliability of measurement is the cornerstone of this objectivity. The supervisor/consultant should establish the reliability of the behavior technician's observations prior to or early in the baseline observation (1) for each new target behavior, (2) for each type of measurement system, and (3) in each new situation for each

b. The behavioral objective or goal of the program, including the time frame.

c. The operational description of the behavioral method.

d. The schedule for use of the method.

e. The data to be collected and the means to assess progress toward the objectives.

f. The control or probe techniques to determine the necessity of continuing intervention.

g. The conditions under which this specific plan (program) is changed or modified.

client. This may be done by initial training sessions for each new behavior. Reliability of measurement is accomplished through parallel but independent observation of the behavior by the supervisor/consultant and the technician, each using the description of the behavior as written. Adequate reliability should be used as a guide to refining and qualifying the criterion used by the technician. At least one random spot check should follow this initial assessment. Behaviors which have a very low rate of occurrence may be excepted, but the supervisor/consultant remains responsible for such exceptions. The assessment sessions and substitute consultations (re: low rate behaviors) should be documented and made a part of the client's permanent record. Adequate reliability should be obtained without feedback during its assessment. These procedures should be documented in the client's chart.

h. The person(s) responsible for the plan (program).

6. The behavioral program supervisor for the service or facility should/shall participate in the development of the individualized plan.

7. Any ABI that clearly affects the health of the individual requires participation of appropriate medical or other health professionals on the multidisciplinary team and regular review process.

7. Similarly, one should always consider whether there is a medical problem causing or even magnifying the present problem. For example, an individual with an itchy rash may act out causing disruption to your program when a salve might prevent the problem.

8. Systematic Timeout, referring to the removal of an individual from a situation, occurs only during the behavioral program for no longer than an hour in extraordinary cases, and under direct observation of persons conducting the program. Systematic timeout is used only as an integral part of an individualized program that leads to a less restrictive way of managing, and ultimately to the elimination of the behaviors for which the technique is employed.

   If an individual exhibits behavior or experiences conditions that are a hazard to his/her health and safety, the use of systematic timeout requires continual visual observation and a physical situation that allows immediate access.

Definition

Seclusion is defined as the placement of an individual in a room or other area from which egress is prevented, and the individual cannot be observed by any staff member, except when the client is under observation as part of a systematic timeout program that meets all explicable standards.

9. Food. When food is provided or withheld as part of a behavior management program, its effect on nutrition and dental status is considered.

a. Foods that may be deleterious to health are not used as rewards unless it is documented that alternative rewards have been tried without success. Questions as to what foods may be deleterious to health are to be answered by an appropriate health professional.

b. Behavior management programs do not employ, or result in, denial of a nutritionally adequate diet.

10. Whenever restraint devices or behavior control drugs are employed to suppress maladaptive or problem behaviors, the individual's record will document the fact that less restrictive methods of modifying or replacing the behavior, including ABI, have been systematically tried and have been demonstrated to be ineffective. If sufficient cause exists for not trying alternatives, these reasons will be documented.

10. Emergency Procedures-Restraint

Definition

Restraint refers to any means employed to prevent a behavior from occurring.

Restraints are only permissible under circumstances in which the supervisor feels that they are absolutely necessary to protect the client from injury to himself or others. Client behaviors requiring emergency restraint might include severe self-abuse or aggression.

Restraint is not treatment and should not be used as such. Restraint should only be a temporary measure to prevent injury while an appropriate treatment intervention is planned by the supervisor and staff. The following safeguards are designed to prevent inappropriate use of restraints.

a. Restraints will be allowed only when the client's behavior poses an immediate threat to the safety of himself and/or others.

STANDARDS

11. Except when used as a timeout device, in accordance with applicable ABI standards, physical restraint is employed only when absolutely necessary to protect the individual from injury to himself or herself or to others, and restraint is not employed as punishment, for the convenience of staff, or as a substitute for program.

12. Physical restraint is used only as an integral part of an individual program or educational plan by a multidisciplinary team to lead to a less restrictive way of managing, and ultimately to the elimination of, the behavior for which the restraint is applied.

13. Medication (chemical restraint) is not used as punishment, for the convenience of staff, as a substitute for a program, or in quantities that interfere with an individual's developmental program.

TECHNICAL NOTES

b. Restraints will ordinarily not continue for a period exceeding two days. This time will allow for the designing and implementation of appropriate treatment procedures. Exception: well detailed programs for slowly decreasing the amount of restraints. Such programs would not exceed ten days without special waiver from the appropriate review committee. Physical restraints should be checked at least once every 30 minutes by the behavior technician.

c. Restraint of any kind shall not be used as punishment, for the convenience of the staff, or as a substitute for adequate programming and shall not cause harm or injury to the client.

11. Where restraint has been identified as a potential positive reinforcing event, it may be used as part of a positive program to decrease undesired responding. Such a program should be treated in terms of approval and review as if it were a Category 3 intervention.

14. Drugs used for behavior control are utilized as an integral part of an individual program, or educational plan designed by a multidisciplinary team, to lead to a less restrictive way of managing, and ultimately to the elimination of, the behavior for which the drugs are employed.

PART I

SECTION II

INDIVIDUAL PROTECTIONS

The technology of behavior modification involving the control of human behavior has raised many constitutional and ethical issues regarding the rights and treatment of individuals. Nonetheless, these guidelines provide the basic policies and procedures to safeguard the individual rights.

This Section is presented in two parts: A. Individual Rights. B. Due Process.

A. INDIVIDUAL RIGHTS

STANDARDS | TECHNICAL NOTES

1. All individuals (including the parent or surrogate who can act in behalf of the individual) who may benefit from an aversive behavior intervention have the right:

   a. To be identified and assessed to determine their need.

   b. To adequate and nondiscriminatory assessment, either by the service or facility, or by an independent outside agency.

   c. To participate when appropriate as outlined in these guidelines in the development of the written individualized education or program plan that implements ABI.

   d. To have their parent(s) participate in the development of the individualized program plan as appropriate to legal status.

   e. To the provisions for the least restrictive effective alternatives for ABI procedures.

   f. To insure maximum involvement in programs for persons who are nonhandicapped.

   g. To the maintenance of confidentiality of information.

   h. To have access to all their own records when legal requirements are met, and for parents to have access to the individual's record when acting legally in their behalf.

   i. To have the written individualized plan implemented as soon as possible.

STANDARDS	TECHNICAL NOTES
j. To have competent and qualified personnel implement and monitor the written individualized plan.	
k. To be fully informed about the purposes, actions, and outcomes of the ABI.	
l. To have procedural safeguards and protections in the determination of the selection and implementation of ABI.	
m. Periodic review by staff of progress toward the goals and objectives in the individualized plan.	
n. To have parent or self-give informed consent when a service or facility proposes to initiate or change the identification, assessment, or ABI for the individual when age requirement is met and when appropriate.	n. "The keynote to any intrusion on the body of a person must be full, adequate, informed consent." Kaimowitz V. Department of Mental Health (420 U.S. Law Week 2063).
All agencies shall notify persons of these rights.	Since due process is not a static thing, it cannot be described precisely or in unchanging terms. This is particularly true with regard to the use of behavioral procedures. The state of the art changes. Minimum acceptable standards grow with the development of improved behavioral strategies and techniques. A restrictive or aversive intervention that might well have been irreproachable at one point in time, can be evaluated two years to two months later as violating an individual's right to substantive due process because it no longer provides the least restrictive alternative. Why? Because a new medication, or a new instructional design, or a new nutritional approach to the target behavior has supplied an alternative that is less restrictive.

5 criteria for LRA Pr

The primary purpose of the due process guidelines is to ensure provision of substantive due process to each person with whom behavioral interventions are employed. Since the standards defining what substantive due process is are growing, these guidelines must be flexible enough to allow for evolution.

The following components are required to safeguard the rights of the special needs of the individual before there can be informed consent.

(1) There must be a precise description of the behavioral intervention or the program of interventions to be used. The description and explanation must be in terms and in a language readily understood by the individual or his family or representative.

(2) There must be an explanation of why this program of aversives fits into the plan for the particular individual's least restrictive alternative. The test of whether the explanation satisfies due process..."should be that aversive therapy might be used where other therapy has not worked; where it can be administered to save the individual from immediate and continuing self-injury; where it allows freedom from physical restraints which would otherwise be continued; when it can be administered for only a few short instances; when it allows freedom from physical restraints which would otherwise be continued, and when its goal is to make other non-aversive therapy possible." Martin, Reed, Legal Challenges to Behavior Modification: Trends in Schools, Corrections, and Mental Health. (1975)

(3) A description of treatment alternatives must be provided, including both other aversive procedures and nonaversive programs where possible.

(4) A justification of the purpose and rationale for the proposed program of interventions must be given and fully explained.

(5) Risks, side effects, or special precautions must be set out.

(6) Procedures for documentation must be detailed and baseline data given.

(7) The specific behavior to be extinguished or modified must be described and the correlation between its incidence and situational or motivational cues explained to the best of the treatment or education staff's ability.

(8) The certification of a physician must be presented to the effect that his examination of the individual reveals no medical cause for the behavior to be extinguished that would make the behavior either subject to amelioration by medical care and treatment or impossible to eradicate without endangering the health of the individual.

(9) The time sequence of expected results must be set out.

STANDARDS	TECHNICAL NOTES
	(10) The documentation of a peer review committee that they are reviewing the use of ABI in the context of other affirmative programming in the setting must be available. The names and qualifications of those serving on this committee must be supplied to the persons giving consent and an opportunity for discussion and questioning made available.
	(11) The person or persons giving consent must be advised of their right to refuse consent without penalty contingent on their refusal, their right to withdraw consent at any time, and the means for doing this.
	(12) Provision should be made in the agency's written policy or procedures for a behavioral element to the informed consent process used. This behavioral element must provide evidence that the persons giving consent to use of behavioral procedures understand that for which they have given consent. The means used must be appropriate to the person giving consent. The behavioral element could consist of a post consent questionnaire.
o. To be informed of all rights and due process procedures available to them, including the right to refuse service.	
p. To challenge the decisions and actions of a program which are related to the individual's rights and protections.	

B. DUE PROCESS

STANDARDS	TECHNICAL NOTES
1. Procedures have been established to provide an organized method for resolving differences and assuring the protection of the individual's rights.	1. Issues most commonly requiring review include due process relative to the intervention, questions of professional or ethical judgment, appropriateness, custom, intervention need, and relevance. 7 Tests
2. Due process procedures should/shall be established in accordance with regulations to guarantee fair treatment and protect the rights of the individual.	2. Appeals may be made by the client, parent, or parent surrogate, staff, advocate, member of the public, administrator, monitoring board, or review structure.
3. An individual, a parent, or an agency may initiate a hearing before a fair hearing panel about any decision regarding, and resulting from:	3. E.g., required fair hearings currently outlined in SDE. "A fair hearing must assure the complainant certain basic due process of law. There are several such procedures that are required of providers of services. The Lanterman Act, Welfare and Institutions Code Sections 4700-4725, establishes procedures for providers of state funded care to developmentally disabled persons. Fair Hearing procedures for educational providers are outlined in PL 94-142 and 45 CFR 121a 506-510, California Education Code Sections 56341-56341.4 and California Administrative Code Title 5 Sections 3124 and 3160-3170. "As an example, the required procedures for education related hearings are as follows:" a. The parent and/or individual's appeal. b. The attempted resolution at the local administrative level. c. The local fair hearing before a panel of experts. d. The state review by an Appeal Review Officer.

Before the parent and/or individual's appeal gets to the third level (local fair hearing panel), it is essential that the local top administrator or designee review the reasons for the appeal with the parent and/or individual and attempt to resolve (or negotiate) the problem area.

In order to guarantee that all parties are ensured that an impartial, unbiased decision is made relative to an appeal, the following shall be adhered to:

a. Any party to a hearing has the right to:

(1) Be accompanied and advised by counsel and by individuals with special knowledge or training with respect to the problem of the handicapped individual.

(2) Present evidence and confront, cross-examine, and compel the attendance of witnesses.

(3) Prohibit the introduction of any evidence at the hearing that has not been disclosed to that party before the hearing.

(4) Obtain a written or electronic verbatim record of the hearing.

(5) Obtain written findings of fact and decisions.

(6) Parents involved in hearings must be given the right to:

(a) Have the individual who is the subject of the hearing present.

(b) Open the hearing to the public.

b. Hearings shall be conducted in the English language; when the primary language of a party to a hearing is other than English, an interpreter shall be provided who is competent in the required language.

c. The agency shall inform the parent or individual of any free or low-cost legal and other relevant services available in the geographical area, upon initiation of hearing procedures, or when the parent/individual requests such information.

d. The decision and related materials submitted to the complainant shall be in English, and where appropriate, also in the complainant's primary language.

e. Written notice of the right and explanation of the procedure for requesting a review of the hearing at the state level shall be included with the complainant's copy of the panel's decision.

STANDARDS

a. The identification of the individual's need for aversive behavior intervention.

b. The individual's assessment.

c. The implementation of the individualized plan.

d. The denial, placement, transfer, or termination of the individual in a program on the basis of the behavior problem.

TECHNICAL NOTES

If an appeal reaches the state level, the following shall be adhered to:

The state agency shall conduct an impartial review of the hearing. The official conducting the review shall:

a. Examine the entire hearing record.

b. Ensure that the procedures of the hearing were consistent with due process.

c. Seek additional evidence as necessary.

d. Afford the parties an opportunity for oral or written argument, or both, at the discretion of the reviewing officer.

e. Make an independent decision on completion of the review and give a copy of the written findings and the decision to the parties.

f. The decision made by the reviewing official is final, unless a party initiates civil action.

STANDARDS	TECHNICAL NOTES
e. The individual's situation program is unnecessarily restrictive. f. The alleged denial of individual's rights.	
4. When an aversive behavior intervention becomes very restrictive and intrusive upon the individual, augmented due process procedures to approve, review, and evaluate should be established to guarantee the protection of the individual.	4. In simpler terms, due process is similar to a balance scale. The heavier the interference in the person's life, through an ABI/restraint, medication, or separation from peers, the greater need for due process safeguards at a minimum. Where instances of Category 4 interventions are employed, prior notification of the internal review committees established by the program/facility is required. The review committees must evaluate the situation within one week of the prior notice of the use of a Category 4 ABI.

PART I

SECTION III

REVIEW AND EVALUATION PROCEDURES

Legal and ethical considerations make it imperative that the rights of individuals be protected and that adequate safeguards be established to ensure that the development of individuals will take place in the center of a compassionate, challenging, and normalizing environment. It is, therefore, of great importance that ABI and the effect of these procedures on individuals are regularly examined and evaluated.

These guidelines provide for four levels of review and evaluation. Each level is independent of the other, however, each level will contribute information of value to the total service system.

A. LEVEL ONE - INDIVIDUAL EVALUATION

STANDARDS	TECHNICAL NOTES
1. The purpose for continuous and frequent examination and evaluation of the individualized program for aversive behavior interventions is to assure that:	When ABI is recommended for individuals in a care or educational facility, there must be a responsible person designated in the facility to monitor all the procedures to be carried out in the determination of the need for the ABI, for planning and developing the IPP, for the implementation of the ABI, and for the evaluation of the effect of the ABI.
a. Comprehensive assessment of the individual's behavior has been completed and target behaviors have been defined.	This responsible person represents the first level of the review and evaluation process. This person must evaluate the quality and completeness of the procedures required in the use of ABI for every individual in the facility. If this person is not the responsible administrator of the facility, this does not relieve the administrator of the responsibility for maintaining the appropriate program standards for personnel to use when ABIs are recommended and used for individuals. Therefore, the responsible administrator must set up the monitoring system to evaluate the quality and completeness of the entire process to provide ABI.
b. Effective procedures have been selected to bring about desired behavior change.	There must be a frequent report made to the responsible administrator if other persons are monitoring the process.
c. Specific and frequent measurements are recorded of the individual's behavior.	The emphasis on this level of evaluation and review is that the responsible administrator must perform the first phase of monitoring the procedures which are carried out for each individual.
d. A review process is established to examine data collected on each individual.	Before a facility starts to use ABI procedures, an "agency" committee must review the competency of the facility to follow these guidelines and approve the programs. The "agency" committee is established by each state agency having responsibility for the facility and must be composed of persons knowledgeable of these guidelines and their use.
2. The review and evaluation of the individual's development and progress should include:	
a. A review of the daily collection of data by the direct service staff.	
b. Periodic reviews of the data summaries by the multidisciplinary team.	
c. A written report which includes:	
(1) The results of specific measurements of the individual's development and progress.	
(2) The effect of the methods and techniques used in the ABI program.	

Reviewed By STATE Program Committee prior to use of ABI

(3) The progress of the individual toward achievement of the goals and short-term objectives specified in the ABI program.

(4) Recommendations for specific program changes or continuation.

B. LEVEL TWO - INTERNAL PROGRAM EVALUATION

STANDARDS	TECHNICAL NOTES

1. The purpose of internal program evaluation is to assure that:

   a. The aversive behavior intervention techniques employed are the least restrictive and the most effective procedures.

   b. The rights of individuals are protected.

   c. Legal and/or regulatory requirements have been met.

   d. There is evidence of planning for program improvement.

   e. There is appropriate personnel assigned to implement an evaluation plan.

2. Each service or facility shall/should develop and carry out a program evaluation plan to include the following:

   a. The provision for program evaluation to be completed at least annually.

   b. A review of the adequacy of assessments to assure adherence to the least restrictive, effective behavioral procedures.

   c. A review of the effectiveness of the ABI implementation procedures as outlined in the individualized education program or individual program.

   d. A review of the effectiveness of personnel to carry out the prescribed procedures, including the ratio of service staff to the individual.

The second level of evaluation or review of a program in a facility which uses ABI requires that personnel intensively review and examine the procedures and processes for delivering ABIs.

Whereas, the first level requires almost a daily examination of the processes and procedures being used for individual cases, this second level of review requires that all the data collected for each individual will be aggregated and compiled to show the quality and effectiveness of the total program.

Data gathering procedures will have to be anticipated and procedures designed to collect, compile, and retrieve information. Personnel in the facility will have to be assigned to carry out the program evaluation plan which should be completed at least annually. If personnel are not available in the facility to carry out program evaluation activities, the facility should contract with outside persons to complete this phase of the review process.

Facilities have the option to establish independent review structures through the utilization of a peer review committee and/or a human rights committee. These committees can perform valuable review and consultative services to a facility.

e. A review of progress toward achievement of the goals and objectives by all individuals in the program.

f. Utilization of a multidisciplinary evaluation team composed of members of the local program.

g. A written report that is available for public access.

h. Procedures for the evaluation results to be utilized by program management to make necessary program changes.

i. There shall be specific program option to establish either or both of two independent review structures for the process of internal program evaluation.

(1) A peer review committee may be established which can provide review and advice regarding technology and procedures, personnel qualifications, and other program related performance factors. This committee shall primarily be a professional standards body for the program or facility.

(2) A human rights committee may be established to review and monitor human rights and civil safeguards for the program or facility and shall include consumers and community representatives.

C. LEVEL THREE - EXTERNAL REVIEW AND EVALUATION BY REGIONAL TEAMS

STANDARDS

1. The purpose of the external review and evaluation by regional teams is to assure that an independent team will evaluate the aversive behavior interventions used in California services facilities. The regional review team should:

   a. Determine the adequacy of program procedural safeguards.

   b. Evaluate professional quality and program methodology.

   c. Determine the technical adequacy of aversive behavior intervention programs.

   d. Approve severely restrictive aversive interventions prior to their initiation unless such approval has been obtained from the level II committee.

   e. Meet at least quarterly to review programs within a jurisdictional region.

   f. Be composed of persons who encompass demonstrated and recognized competence in:

      (1) Planning, programming, and implementing ABI and alternatives.

      (2) Administration of programs using behavioral procedures and alternatives.

      (3) Program evaluation.

      (4) Developmental and educational programming.

      (5) Legal advocacy.

   g. Prepare written reports and utilize other lines of communication for interaction with the local service or

TECHNICAL NOTES

The first and second levels of this review process require procedures and personnel within the facility to perform the first line of program monitoring and review. The quality and completeness of the procedures and processes being used by a facility should be known to the responsible administrator of the facility. Although there may not be common agreement among administrators of facilities as to what constitutes an adequate or effective program, the procedures and processes outlined in these guidelines shall/should be followed in facilities where ABIs are used. These guidelines should bring some consistency and quality to the practice of providing ABI to individuals.

The third level of the review and evaluation process requires the use of external teams which should be established to serve specified regions. These teams should/shall schedule regular (at least annually) on-site reviews of programs using ABI for individuals. These teams should be composed of persons representing multidisciplinary backgrounds, and should have multiagency representation.

The "agency" committees which have approved ABI programs shall provide the regional teams with the list of facilities which have been approved and provided the name of a contact person at each facility.

The regional team(s) should/shall:

1. Review and evaluate all programs which provide ABI.

2. Review the individual and program evaluation procedures described under level one and two of this document.

3. Make on-site visits.

4. Review the appeal procedures available to individuals in the facility and review the type of appeals which were made.

facility, state review committee, and the various State Departments of Health and Education.

h. Recommend modification of state guidelines and standards annually to state review committee.

5. Prepare written report for the facility, the state "agency" committee, and state review committee.

6. Make recommendations for program changes as may be necessary.

7. Communicate to the state review committee recommendations for changes to these guidelines.

D. LEVEL FOUR - EXTERNAL REVIEW BY STATE REVIEW COMMITTEE

STANDARDS	TECHNICAL NOTES
1. The state review committee shall be composed of persons jointly appointed by the Departments of Education, Social, Developmental, and Health Services which should have the responsibility for approving and monitoring programs which employ aversive interventions. The state review committee should: a. Review and amend guidelines and standards for ABI biannually. b. Review evaluation reports submitted by regional review teams semiannually. c. Hold public meetings for consumers and providers to be determined by its policy advisory needs. d. Recommend the establishment of local/regional review teams. e. Monitor the review and evaluation procedures of the local/regional review teams. f. Review appeals of decisions by local/regional review teams. g. Assure enforcement of the guidelines for ABI. h. Advise Licensing and Certification which facilities under the Departments of Social, Developmental, and Health Services jurisdiction are to be granted a special permit to utilize ABI.	A state review committee should/shall be established to perform functions which will have statewide impact on the use of ABI procedures. It should receive much data and information from the preceding levels of review and evaluation in order to effect changes to the guidelines, to determine need for legislative action, to recommend improved procedures. The state review committee shall be available to investigate serious charges of noncompliance brought by a regional team.

i. Effect a liaison between the scientific community and the providers' constituency, including summarizing state of the art developments biannually.

PART I

SECTION IV

PERSONNEL RESPONSIBILITIES AND QUALIFICATIONS

Programs utilizing aversive behavior intervention (ABI) shall/should have the following personnel responsible for the delivery of services: behavioral program (clinical) supervisor,* direct service staff, and direct service assistants. The behavioral (clinical) supervisor and direct services staff shall/should be mandatory for implementation of ABI programs.

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* Supervisor functions, in some instances, may be performed by a consultant.

A. BEHAVIORAL PROGRAM (CLINICAL) SUPERVISOR

RESPONSIBILITIES

1. The legal, social, educational, and psychological well-being of all persons who, by necessity (as outlined in these guidelines), require aversive behavior intervention.

2. The personal supervision and evaluation of assigned service staff and assistants in the performance of ABI.

3. The quality of records which monitor the ABI program and its measurable effects upon the individual.

4. The designing and implementation and quality control of all ABI programming.

5. The implementation of review procedures for individual programming.

6. The provision and assurance of communication channels that allow any staff member to report, in writing, observed misuses of ABI to the appropriate review authority, without penalty to the staff member.

7. The preparation of written reports of any misuse of ABI to the appropriate review authority.

QUALIFICATIONS

1. A behaviorally trained Ph.D. or a person with equivalent professional competencies trained in an institution of higher learning with a recognized curriculum in behavioral technology.

2. An extensive background and practical experience in the application of behavioral procedures.

3. Has had direct experience with the kinds of populations with which the present service is concerned.

4. Able to provide documented experience and demonstrate competency in at least the following areas of expertise: application of behavior modification theory and techniques, ethical and legal factors, and supervisory skills.

COMPETENCIES

1. Application of behavior modification:

   a. Identifies target behavior in relation to antecedents and consequences.

   b. Conducts reliable measurement of targeted behavior.

   c. Carries out a trouble-shooting program to evaluate effectiveness of procedures.

   d. Lists the essential stages in designing and conducting behavior change activities.

   e. Writes a proposal for behavior change program.

   f. Provides a written report of the program effects.

   g. Identifies variables which may contraindicate specific treatment procedures.

   h. Evaluates the appropriate behavior modification procedure to manage behavior problems, specifically (includes, but is not limited to):

RESPONSIBILITIES	QUALIFICATIONS	COMPETENCIES
8. Assurance of continuing staff development relative to procedural, theoretical, and ethical advances in the field through in-service training and/or continuing education opportunities.		(1) Extinction.
9. Participation in recruitment and selection of personnel engaged in ABI programming.		(2) Timeout.
10. Ability to integrate behavioral procedures and ABI into an overall program emphasizing normalization and quality individualized education within a developmental model.		(3) Reinforcement of incompatible behaviors.
11. Integrate individual and family interests with program priorities.		(4) Graduated guidance.
		(5) Restitution.
		(6) Restraint.
		(7) Noxious noises, smells, etc.
		(8) Deprivation of food or water.
		(9) Slapping or spanking.
		(10) Painful skin stimulation.
		(11) Fading out of restrictives.
		i. Is familiar with procedures for arranging contingent relationships between targeted responses and consequences which are available in the natural environment.
		j. Must be able to devise at least two alternative treatment procedures in each of the three levels of intervention restrictiveness.

k. Can analyze stimulus control and other parameters which will maximize generalization of treatment gains of the individual's abilities to a more normalized setting.

2. Ethical and legal issues:

a. Can identify the major ethical issues.

b. Demonstrates the incorporation of ethical standards in program design implementation, communication, and evaluation.

c. Identifies federal and state laws and legal precedents as they affect the conduct of education-treatment activities.

d. Is familiar with the ethical issues of research with respect to the use of human subjects.

3. Theoretical issues:

a. Demonstrates familiarity with current literature on application of nonaversive and aversive procedures.

b. Is familiar with learning principles and the treatment proceedings which have been derived from them.

RESPONSIBILITIES	QUALIFICATIONS	COMPETENCIES
		4. Supervisory issues: a. Demonstrates ability to coordinate and participate in a multidisciplinary team. b. Demonstrates an ability to organize direct service staff. c. Demonstrates an ability to evaluate the effectiveness of direct service staff.

B. DIRECT SERVICE STAFF MEMBER

RESPONSIBILITIES	QUALIFICATIONS	COMPETENCIES
1. The direct implementation of the ABI program.	1. Possess at least a high school diploma or equivalent.	
2. The maintenance of daily records with sufficient detail to measure the effects of ABI on the individual.	2. Evidence of continuing education at college level in area of behavior modification.	
3. The preparation and submission of a written report of any individual's unexpected or unplanned program outcomes to the person providing behavioral program supervision.	3. Demonstrate competency in application of behavior modification theory and techniques, knowledge of the ethical and legal factors as they apply to the population.	
4. Maintenance of regular summary reports detailing the method and effects of program implementation upon the individual's target behaviors, and any other significant observations.	4. Documented evidence of past history of good judgment in providing quality human services.	
5. The preparation and submission of a written report of any need for alteration of the ABI to the supervisor.		
6. The submission of a written report of any observed misuse of ABI to the appropriate review authority.		
7. The personal supervision of service assistants.		

C. DIRECT SERVICE ASSISTANTS

RESPONSIBILITIES	QUALIFICATIONS	COMPETENCIES
1. Carry out alternative nonaversive behavioral procedures. 2. Implement ABI as directed. 3. Maintain reports and records as directed. 4. Report in writing any misuse of ABI to the appropriate review authority. 5. Report to the behavioral program supervisor and/or direct service staff member.	1. Possess a high school diploma or its equivalent. 2. Demonstrate interest in and sensitivity to the needs of individuals participating in the program. 3. Demonstrate good judgment and personal stability.	

OBJECTIVES OF A TRAINING PACKAGE

1. Participants will identify from a list of possible purposes, the purposes underlying the formation of the ABI guidelines.

2. Participants will be able to state the scope of application of the guidelines, with specific reference to the following:

   a. Applicable settings.

   b. Appropriate target individuals.

   c. Identified behaviors to be modified.

   d. Types of interventions to be included under the heading ABI.

3. Participants will specify when the guidelines are not applicable with respect to changing behavior.

4. Participants will state the key underlying philosophical concepts upon which the guidelines rest.

5. Participants will specify when ABI may be initiated.

6. Participants will list the steps which must be taken before ABI is initiated.

7. Participants will be able to identify procedural plan requirements.

8. Participants will be able to identify the individual plan requirements.

9. Participants will state who will participate in the multidisciplinary process.

10. Participants will differentiate between normal and emergency use of ABI.

11. Participants will establish a policy statement which identifies how individual rights are to be protected with respect to the right to:

    a. A technically sound ABI program.

    b. The highest quality ABI program available.

    c. Safeguards guaranteeing that all established program procedures are followed.

    d. Confidentiality.

    e. Due process.

12. Participants will organize a mock review and evaluation procedure for individual and internal program evaluation.

13. Participants will state the rationale and expectations for regional and state review procedures.

14. Participants will identify three exemplary individuals among their existing staff who could meet the qualifications and competency requirements of the personnel responsibilities and qualifications section for the three levels of personnel listed. This task would be accomplished by completing a chart which provides an opportunity to state how each individual meets the guideline requirements. (In the event that qualified individuals are presently not in the employ of a participant, methods for assessing the competencies to use ABI are to be identified.)

Instructions:

The following check lists will provide a means of determining whether you have met the minimum requirements of the ABI guidelines. These check lists are not designed to be all inclusive, but rather to be a reminder of some of the procedural requirements of the guidelines.

1. Do your existing policies include statements which reflect:

( ) a. How ABI is to be used.

( ) b. The staff member(s) who may authorize ABI.

( ) c. The staff member(s) who may implement ABI.

( ) d. The mechanism for monitoring and controlling the use of ABI.

( ) e. How ABI is included in, and coordinated with, a total program of behavior change.

( ) f. The need for an established hierarchy of available behavior change methods which emphasize positive behavior change approaches.

( ) g. The need to actively make available the above policy statements to personnel, the targeted individual, and the targeted individual's family.

2. Have you considered the following in developing a behavior change plan?

( ) a. An environment which is not stigmatizing and supports the desired behavior change.

( ) b. Alternative strategies for behavior change.

( ) c. The undesirable long- and short-term side effects.

( ) d. The condition(s) under which a specific procedure is contraindicated.

( ) e. The time needed to complete the plan.

( ) f. The frequency or how often the procedure should be implemented.

( ) g. The staff needed to carry out the procedure.

3. Have you made a thorough multidisciplinary assessment of the individual prior to initiation of ABI, including measurements of:

( ) a. Social interaction.

( ) b. Communication.

( ) c. Physical development and health.

( ) d. Cognitive and adaptive status.

( ) e. Learning style and level.

( ) f. The targeted behavior.

( ) g. The conditions which contribute to the occurrance of the targeted behavior.

4. Does each individual selected to participate in an ABI program have a written plan which includes:

( ) a. Provisions to teach the circumstances under which the behavior can be exhibited appropriately.

( ) b. Methods to shape the behavior into more appropriate expressions.

( ) c. Procedures to replace the maladaptive behaviors with those that are adaptive and appropriate.

( ) d. The targeted behavior stated in objective and quantifiable terms.

( ) e. The behavioral objective or goal of the program, including the time frame.

( ) f. The operational description of the behavioral method.

( ) g. The schedule for use of the method.

( ) h. The data to be collected and the means to assess progress toward the objectives.

( ) i. The control or probe techniques to determine the necessity of continuing ABI.

( ) j. The conditions under which this specific plan (program) is changed or modified.

( ) k. The person(s) responsible for the plan (program).

5. In protecting the rights of individuals participating in ABI, you have considered the following:

( ) a. The adequacy of the assessment techniques employed.

( ) b. The potential for the assessment procedures to be discriminatory.

( ) c. The inclusion of the targeted individual or parent in the ABI planning.

( ) d. The use of least restrictive alternatives in planning the intervention procedures.

( ) e. The degree to which you have maximally integrated nonhandicapped individuals in the intervention procedure.

( ) f. The accessibility of the targeting individual's records.

( ) g. The extent to which ABI procedures are implemented with the least delay.

( ) h. The extent to which the individual targeted and/or parents are informed of the ABI procedures.

( ) i. The adequacy of the staff carrying out the ABI program.

( ) j. The enactment and implementation of procedural safeguards and protections.

( ) k. The conducting of periodic review of staff progress toward the goals and objectives of the ABI plan.

( ) l. The possession of signed informed consent forms.

( ) m. The informing of all ABI participants of their rights, including the right to refuse services, and to challenge the decisions or actions of a program, which are related to the individual's rights and protections.

6. In developing a set of procedures for individual review and evaluation, you should consider the following:

( ) a. A review of the daily collection of data by the direct service staff.

( ) b. Periodic reviews of the data summaries by the multidisciplinary team.

( ) c. In writing, a statement of the results of specific measurements of the individual's development and progress.

( ) d. In writing, a statement of the effect of the methods and techniques used in the ABI program.

( ) e. In writing, a statement of the progress of the individual toward achievement of the goals and short-term objectives specified in the ABI program.

( ) f. In writing, a statement of the recommendations for specific program changes or continuation.

7. A program evaluation plan should consist of the following:

( ) a. The provision for annual review.

( ) b. A review of the adequacy of assessments to assure adherence to the least restrictive effective behavioral procedures.

( ) c. A review of the effectiveness of the ABI implementation procedures as outlined in the individualized education program or individual program.

( ) d. A review of the effectiveness of personnel to carry out the prescribed procedures, including the ratio of service staff to the individual.

( ) e. A review of progress toward achievement of the goals and objectives by all individuals in the program.

( ) f. Utilization of a multidisciplinary evaluation team composed of members of the local program.

( ) g. A written report that is available for public access.

( ) h. Procedures for the evaluation results to be utilized by program management to make necessary program changes.

( ) i. The establishment of two independent review structures for the process of internal program evaluation -- a peer review committee and a human rights committee.

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William Bronston, M.D., Chairperson
Interagency Task Force on
Behavioral Intervention Guidelines