Functional Behavior Assessment
Report of Findings and Recommendations

Month 00, 0000

Student: AAA
School:
District:
Teacher/Case Manager:
Behavior Analyst:

Date of Birth:
Age:
Classroom: SID/PID Self-Contained

Dates of Assessment:

- Observation and work with student and classroom staff: January 10, 20, 27, February 10, March 2, 9
- Teacher interview: January 10 and throughout (including paraprofessional staff)
- Parent Interview: February 17, 2017

Problem/Functional Assessment

AAAA, "AA" is an nine-year, six-month old boy in Ms. BBBBB's classroom at Atha Road Elementary. His classroom serves students with severe and profound intellectual disabilities. AA has a diagnosis of autism spectrum disorder, severe intellectual disability and speech language impairment. He also has a seizure disorder; Mrs. CCCCC, AA's mother and Ms. BBBBB reported there was a period of increased frequency of seizures in 2013/2014 resulting in a lengthy hospitalization, and reported declines in behavioral functioning.

AA was referred for a functional behavior assessment (FBA) of his challenging behavior, which includes self-injurious (SIB), tantrums, aggression and property destruction. SIB, which includes head hitting and banging, and biting self (typically his hands) is the most severe and dangerous of the behaviors with events often occurring between 50% and 60% of observation intervals during a school day. The behavior has caused a permanent swelling or hematoma on his forehead and ears ("cauliflower"). He has also injured his nose, eyes and hands. More severe or lengthy behavioral episodes result in tissue reddening, "fresh" or additional swelling, abrasions and lacerations. These episodes require the use of protective equipment (helmet with partial face guard, Rifton® chair and splints, all approved via physician order), and while the equipment is being applied AA often becomes aggressive including hitting, kicking, pinching and biting others. On the other hand, AA engages in mild head hitting that may occur independent of other target challenging behaviors and appears to be stereotypic or, possibly, a habit. In fact it often occurs just prior to or while his falling asleep.

In addition to the aggressive behavior that occurs with episodes of SIB, AA engages in aggression that appears to be more "random" including reaching out and hitting another or pulling someone's hair as he ambulates from one location of the classroom to another. Property destruction also occurs concomitant with SIB, and less frequently, independent

of SIB. This includes swiping items from tables, throwing objects, pulling an adult's hair. AA tantrums include any combination of SIB, crying, screaming, and falling to the floor. Lastly, he displays non-aggressive spitting (placing his tongue between his lips and blowing), drooling and hand mouthing; these behaviors were not the subject of this assessment.

AA was enrolled in the Marcus Autism Center, approximately 2013 (report was not available) where he participated in an 18-week program of functional analysis and followed by the design and initial implementation of an intervention. Further, he has was admitted to Laurel Heights Hospital's acute treatment unit for 18 days in April, 2016, for behavioral treatment, leaving with a behavior plan for the home and community.

SIB, tantrums, and aggression were the primary focus of this functional assessment. The assessment included teacher and parent interview, observation of AA during several activities yielding descriptive (e.g, antecedent, behavior, consequence) information; trials of simple, possible initial intervention procedures; and assistance in intervening during tantrums, including the noted severe SIB. In addition the Functional Analysis Screening Tool and the Questions about Behavioral Function were used, both designed to pinpoint possible functional variables, or events in AA's environment, related to his challenging behavior.

Teacher and Parent Interviews

Ms. BBBBB

Information from the interview with Ms. BBBBB is referenced throughout the report where relevant. Prior to any work by this clinician and working with Ms. BBBBB, she summarized her assessment of AA's behavior as related to several variables including: escape from demands, tangible items (their removal or presentation), not doing what he wants when he wants, and pain or discomfort.

Mrs. CCCCC

Mrs. CCCCC reported that AA has many health challenges related to his developmental disabilities. These include disordered sleep, which has been effectively treated with Clonidine (now used only as needed), and digestive problems—most notably, constipation. He has been hospitalized related to constipation and receives MiraLax each day. Mrs. CCCCC reported AA's hearing is good and that he has astigmatism, though the impact on his vision is unclear. AA is allergic to some medications (Zofran, Haldol). He eats finger foods and will use a fork or spoon with hand over hand guidance to prevent throwing.

Mrs. CCCCC's assessment of AA's challenging behaviors is consistent with much of Ms. BBBBB's assessment. She shared the following:

- AA's SIB, and other challenging behaviors are related to pain, either unidentified (e.g., headaches, constipation, gas), or as caused by the SIB

- AA's challenging behavior is worse when he doesn't sleep well
- The behaviors are more likely and more intense when he has a cold
- He prefers to play and avoids demands, and will display challenging behavior when required to engage in a non-preferred task (e.g., diaper change)

Mrs. CCCCC shared that the previously mentioned evaluation at the Marcus Center showed his challenging behavior to be related to multiple variables, and that the treatment outcomes from the clinic based treatment was short-lived due to difficulty replicating the procedures at home. As noted, a report was not available.

AA was admitted to the hospital over the Thanksgiving 2016 break to begin a change of course in his medications, including the psychotropic and antiepileptic medicines he had been taking for many years. On November 20, Fentanyl was initiated, due to Mrs. CCCCC's and the pain management team's assessment that AA's SIB and other behavioral challenges are related to pain. At the same time the following medications were tapered, with all fully discontinued by January 9, 2017: Seroquel, Clonidine, Neurontin, Trazodone, Valproic acid and Trileptal.

AA currently receives:

- Fentanyl 12 mcg/hr (via transdermal patch)
- Scopolamine (to treat excessive drooling, via transdermal patch)
- Miralax (to treat constipation)
- Clonidine, as needed for sleep

Mrs. CCCCC reported that AA's behavior has improved substantially through the medication adjustment process. His SIB and tantrums were reported as less frequent and intense/severe, and, that he is much easier to redirect.

Mrs. CCCCC's primary goal for AA is that he "have the best quality of life possible." In addition, she wishes others understood his communication as she does and would like to see his skills improved in this area. Lastly, she reported that AA has "issues with food sensitivity and acceptance" and consumes five cans daily of Pediatric Complete formula. She would like to see him learn to accept more foods and decrease the use of formula.

Classroom Observations, Descriptive Functional Assessment and Interview Findings

I observed AA during several classroom activities including arrival, morning group activity, breakfast, 1:1 instruction, and less structured times in the classroom. The observations included a descriptive functional assessment (possible setting events, and antecedents and consequence variables related to target behaviors). As reported above, there was a dramatic decrease in AA's challenging behavior just as this assessment was beginning. The data below suggest this change is related to recent, significant, adjustments to AA's medication regimen (discussed in detail in the Data Discussion section). Ms. BBBBB reported that, in addition to decreased rates of the behaviors there

was also a significant decrease in intensity or severity of behavioral events. Thus the initial part of the assessment included many periods when AA was happy (smiling, "relaxed") and calm, and he participated in classroom activities in the absence of the reported behaviors. This allowed for observation of AA's performance in instructional activities with limited disruption, while other parts of the assessment included low to high severity target challenging behavior. Observations during classroom activities were as follows:

Morning group/song

AA was physically prompted to sit as the morning song began. The classroom staff sang along and clapped. AA clapped 2-3 times independently. When a switch (a simple assistive communication device) was presented AA readily touched the "hi" switch, then touched his picture on two consecutive trials.

- He dropped a container holding beads continually throughout this activity, which may have helped him participate. Dropping objects that make noise is reportedly a highly preferred, perhaps reinforcing activity.
- Following his turn to say "hi", AA dropped from his chair to the floor and began lifting (tilting) and dropping the chair leg, which appeared to be maintained by the noise made by the dropping.
- I moved the chair away, and requested a "high five"; when AA responded I dropped the bead container. Several trials were repeated. This simple instruction-response-reinforcement contingency ("high five" – hand slap exchange – noise) appears very effective with AA at times of low rate challenging behavior.
- He then responded to the instruction "stand up."

AA participated in a diaper change in the absence of SIB, aggression tantrums and property destruction. These behaviors are reported as being highly likely during diaper changes, prior to the recent period of improved performance.

One-to-one instructional activities:

I observed Ms. Cheryl Johnson's speech session with AA. He is working on an early phase of a picture communication system, making an exchange of a generic (blank) picture card for his fork, allowing him to take a bite of breakfast. His hands are shadowed or held down between trials to minimize grabbing items on the table or staff. When AA receives the fork he is physically guided to take a bite. I offered a suggestion on how to position oneself in relation to a student when physically guiding—with one's body and guiding hand oriented the same as student's body and hand. I also suggested offering a bite of food, rather that the fork, contingent on the picture response, so that reinforcement (if in fact food is reinforcing) follows the communicative response immediately. This may lead to faster skill acquisition.

During Ms. BBBBB's 1:1 session with AA, she worked on stacking various colored shapes onto pegs. AA participated for 10 minutes. He began dropping the wooden shapes, again, seeming to enjoy to the noise. I demonstrated how to use this as a

reinforcer during the teaching session, by first requiring that a shape be placed on a peg, followed by giving AA a peg for dropping/spinning. He completed several trials in this fashion. This session ended with AA falling to the floor, appearing uncomfortable, or in pain. He began to whine, and then cry (with tears). He then began drooling, banged his head on his hands several times, and hit staff when they attempted to block. His helmet was applied and splints were considered but not needed. He then lay on a beanbag chair and fell asleep. Ms. BBBBB described this event, particularly the crying, as "not typical." The episode appeared to be related to discomfort or fatigue; it is possible that one or the other made him more sensitive to the instructional demands, following several successful trials.

Arrival

During an observation of AA's arrival to school in the morning, he was falling asleep ("dozing"). When in the classroom he was removed from his chair. He fell to the floor and began banging his head against his forearm, though with limited force. Nevertheless, his forehead and nose became red. His helmet was applied—he then moved to the beanbag chair and fell asleep. The helmet was removed once he was asleep. Being moved from a preferred (chair and dozing) to less preferred activity/location precipitated the self-injury. In addition, he was fatigued, likely a setting event to many of AA's difficult behavior—i.e., when tired he is more likely to respond adversely to environmental events such as moving from a preferred to a less preferred activity/location.

On another arrival occasion, while still in his chair, AA was given a toy octopus (a favorite toy). He repetitively dropped the toy, followed by spitting ("raspberries"). When I removed the toy, he began to hit his head. He later began chewing on a strap from his chair; when removed, he began to head hitting. On one occasion, I blocked the response and following a moment of no attempts re-presented the desired toy. This sequence suggests SIB is related to the removal and presentation of favored objects, or tangible reinforcement. Following the removal of the object, AA may begin SIB, which may be immediately followed by the presentation of a toy or favored object, reinforcing the self-injury.

Less Structured Activities

AA was observed on several occasions in the "sensory" room, which is equipped with a swing, objects for visual stimulation on the wall, therapy balls, etc. He prefers this location when he is not involved in direct instructional activities, and at times, during instructional activities. A severe episode of SIB and aggression occurred on one occasion when AA, had difficulty either entering or removing himself from the swing. He was assisted to leave the swing and once free from the swing began to bang his head. I attempted to return him to the swing, which he resisted and led to increased SIB and aggression. The episode escalated to the pointed where AA and staff were injured. The helmet, Rifton and splints were used. After a struggle to apply the equipment he calmed. It is possible that protective equipment serves to reinforce the problematic behavior. Not

all episodes end in this manner—so the equipment is used intermittently, and if it is reinforcing, this can lead to behavior that is highly resistant to change.

Related, AA left the general classroom following morning group, breakfast and individual instructional activities. He went into the sensory room, which is not available during the morning. He lay on a mat and began banging his head. To assess for attention as a potential reinforcer, I approached AA on each of several successive head bangs and offer a common attention response. For example, "AA you're going to hurt yourself", or "AA, stop banging your head." On each of several trials, AA looked at me and stopped banging, resuming after 15-20 seconds, at which time this pattern continued. Under these circumstances, attention appeared to be a controlling variable.

The attention trials were followed by a test of tangible reinforcement or, possibly "alone" as a variable maintaining SIB and AA's other challenging behaviors. This was conducted by prompting AA to leave the sensory room, first verbally and then with physical guidance. When he would attempt to fall to the floor, a blank "pictorial" icon was placed in his hands by Ms. BBBBB, which I removed while stating "my turn"; and "oh, AA, you want more turn in the room, sure." We repeated this on several trials with AA resisting less on subsequent trials. This suggests the following: 1) the sensory room may be controlling variable of challenging behavior, and/or 2) time alone or away from others may be functioning to reinforce the tantrums, 3) AA can learn a simple request ("mand") response to access desired items.

After several trials of the picture exchange procedure, AA's tantrum/SIB escalated. It was discerned that he had had a BM, so was taken for a diaper change. He lay still for a diaper change, after which all challenging behavior ceased. This again suggests AA may be responding to discomfort with attenuation of the discomfort possibly reinforcing the tantrum that preceded it. For example, AA becomes constipated, engages in target challenging behavior, is changed and feels better (reinforcer).

Functional Analysis Screening Tool and Questions About Behavioral Function Findings

The Functional Analysis Screening Tool (FAST) was completed by Ms. BBBBB as part of the current assessment, prior to my work with she or AA. The FAST is designed to identify or pinpoint variables that influence the target challenging behavior; in this case Ms. BBBBB completed the tool for SIB. She endorsed items related to <u>"automatic reinforcement" (sensory stimulation)</u> most frequently, suggesting the behavior is reinforced by positive sensory reinforcement and occurs independent of environmental events. Social reinforcement in the form of <u>escape</u> (e.g., from demands or other stimulation aversive to the student) was the second most frequently rated category. Social reinforcement in the form of attention and automatic reinforcement in the form of pain attenuation were third and forth, respectively, in the ranking of variables considered important.

The Questions About Behavioral Function (QABF) is similar to the FAST in that it is useful as an indirect assessment of the function of an individual's behavior, and can serve as one tool in the FBA process. The results of the QABF, also completed by Ms. BBBBB, scored items in the categories escape from demands, environments, others, and physical variables yielding the highest scores available for number of items endorsed and severity. Non-social variables, such as those described above as automatic reinforcement (sensory) also scored high in both categories.

Preferences/Reinforcers

Preferences were assessed through the interviews, classroom observation and direct work with AA. All reported or observed the reinforcing properties of noise produced by dropping hard objects—this was directly illustrated in the "high five" interaction and stacking shapes on pegs activities described above. Social attention, hugs or chest squeezes, coke (and carbonated beverages generally) and time alone, particularly in the sensory room, were also identified as preferences, and may have value as reinforcement during instructional trials and interventions targeting reduction of challenging behavior.

Data Collection Considerations

The data collection used by the classroom staff included a 30-minute partial interval recording tool for SIB, tantrums, and property destruction, with frequency recording for aggression (data from this tool are displayed later in this report and the primary data considered in this functional assessment). Aggression was recorded during the same intervals as the other behaviors—as a more conservative, and likely more accurate index, aggression is also considered as percentage of 30-minute intervals.

Following interview of AA's teacher Ms. BBBBB, and review of the data using the tools in place, the high rates of the target challenging behavior suggested that a momentary time sampling (MTS) tool may be more efficient. The MTS would allow for data entry at five minute intervals with recording only when the behavior was observed at the moment the five-minute interval ended. However, as reported below, a dramatic decrease in AA's challenging behaviors occurred just following the beginning of this assessment. Thus, Ms. BBBBB and I agreed, leaving the current tool in place would be sufficient.

The MTS tool was initiated following a recent (early March, 2017) uptrend in the behavior. After a morning of use, Ms. BBBBB reported the MTS approach was resulting in many incidents of challenging behavior being unrecorded. Therefore, the data collection method was changed to five-minute partial interval recording, wherein the behaviors are recorded if they occur at any time in an interval.

Following this clinician's most recent interaction with AA when engaged in a tantrum and SIB, the Self-Injury Trauma Scale (SITS) was initiated and will be completed at arrival and departure. The SITS will provide a measure of tissue damage/physical injury and serve as a secondary measure of SIB during assessment and intervention processes.

Finally, a record of each bowel movement (BM) at school is being kept to allow evaluation of the relationship between constipation/BMs and the target challenging behavior.

Behavioral Definitions

Classroom data collection tool:

SIB: Biting self, hit hitting with open or closed hand.
Aggression: Biting, pinching, hitting, kicking others, digging fingernails into other's skin (includes attempts)
Tantrums: Crying with or without dropping to the floor/wiggling around floor, lasting for at least five seconds.
Property destruction: throwing things, swiping items off table, climbing on furniture, digging into garbage.

Five Minute Partial Interval Recording Tool

SIB: Head hitting, banging head, biting self, or attempts.
Aggression: Head butting, biting others, kicking, scratching or attempts
Tantrums: Any combination of self-injurious behavior, falling to the floor, and screaming.

Classroom Data

The following figures show AA's behavior as sampled using the 30-minute partial interval tool that was ongoing when the assessment was initiated. The figures show a baseline period (or period prior to the most recent medication changes), the period when the medication Fentanyl was introduced and the other medicines were tapered, and lastly, the period with AA receiving only Fentanyl, Scopolamine, and Clonidine as needed for sleep.

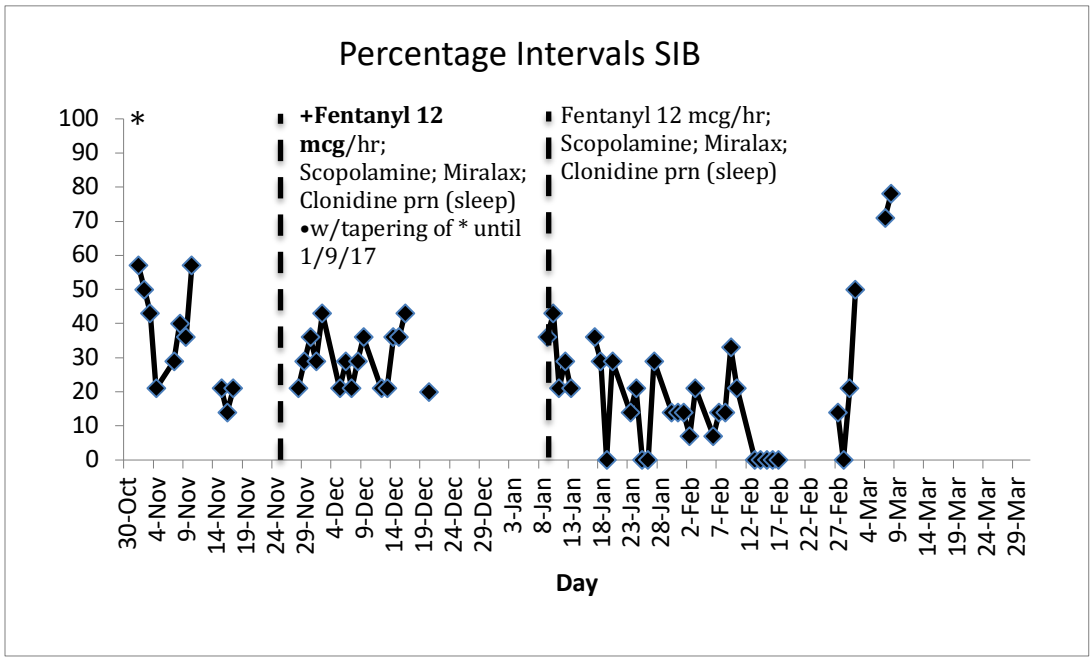

Figure 1: Percentage intervals self-injury during FBA with ongoing medication change.
*Seroquel – 200 mg TID; Clonidine – 0.1 BID; 0.2; Neurontin – 100 mg BID, 200 mg HS; Trazodone – 50 mg HS; Valproic acid 180 TID; Trileptal; Scopolamine; Miralax

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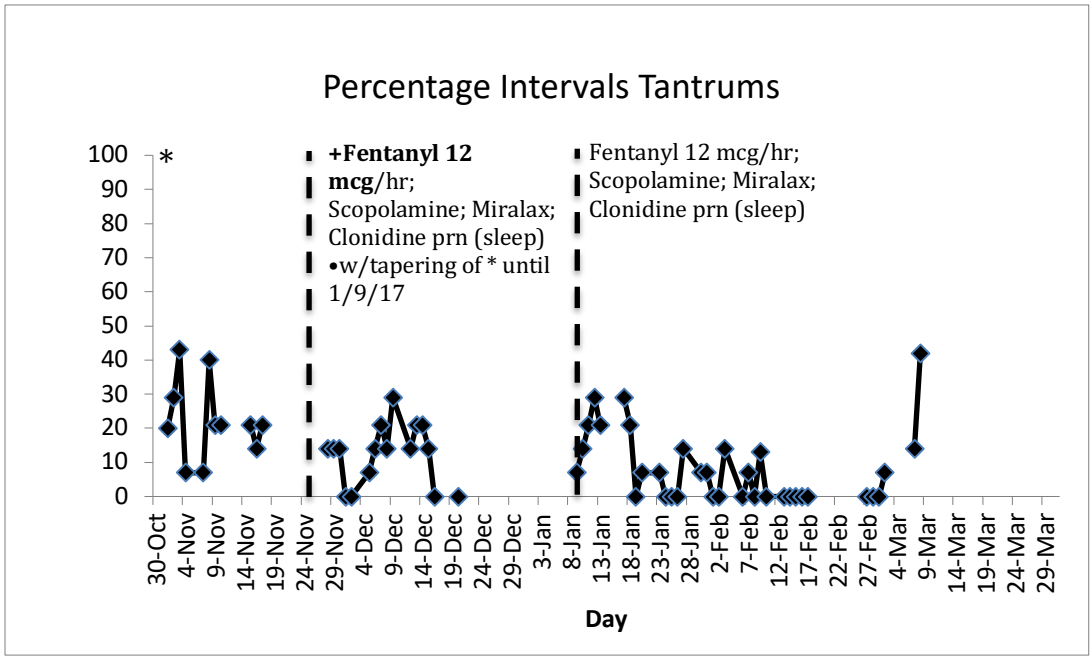

Figure 2: Percentage intervals tantrums during FBA with ongoing medication change.
*Seroquel – 200 mg TID; Clonidine – 0.1 BID; 0.2; Neurontin – 100 mg BID, 200 mg HS; Trazodone – 50 mg HS; Valproic acid 180 TID; Trileptal; Scopolamine; Miralax

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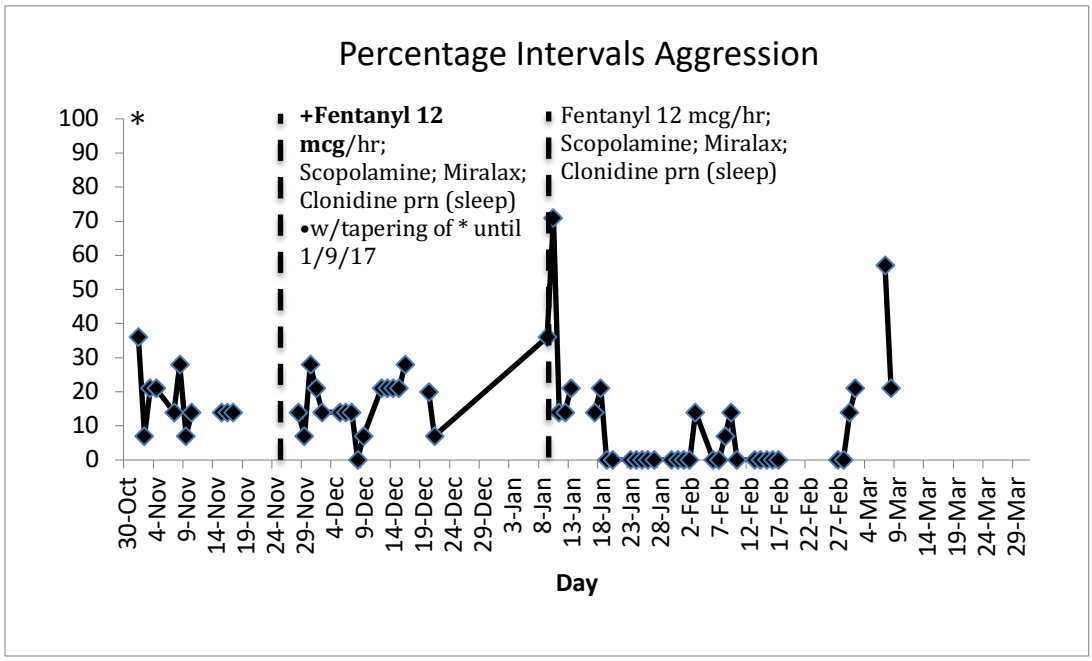

Figure 3: Percentage intervals aggression during FBA with ongoing medication change. *Seroquel – 200 mg TID; Clonidine – 0.1 BID; 0.2; Neurontin – 100 mg BID, 200 mg HS; Trazodone – 50 mg HS; Valproic acid 180 TID; Trileptal; Scopolamine; Miralax

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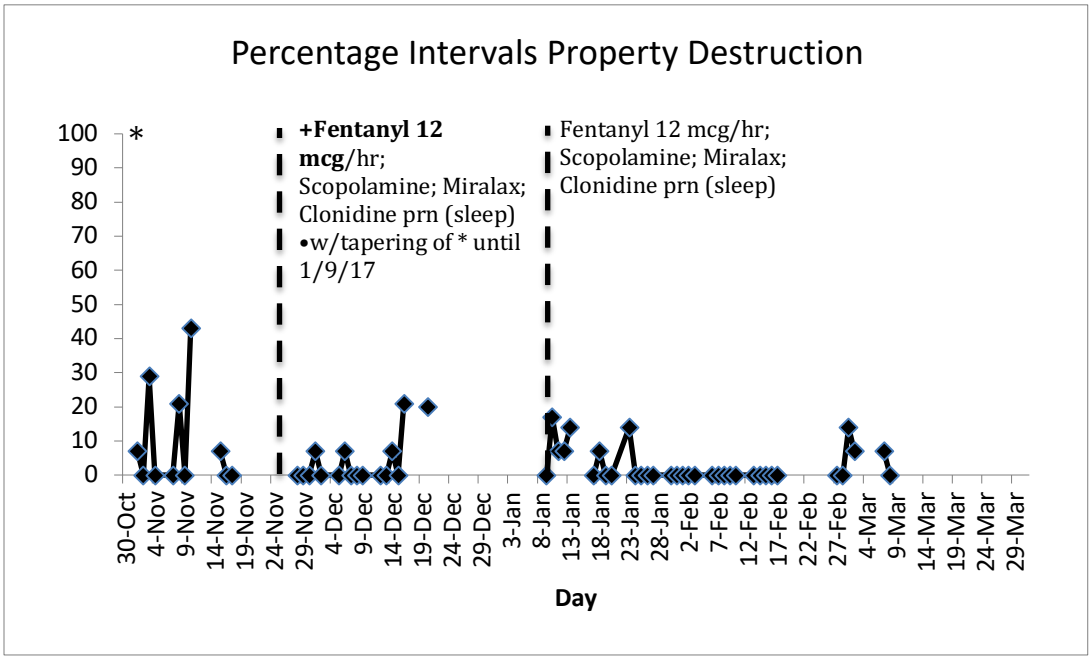

Figure 4: Percentage intervals property destruction during FBA with ongoing medication change. *Seroquel – 200 mg TID; Clonidine – 0.1 BID; 0.2; Neurontin – 100 mg BID, 200 mg HS; Trazodone – 50 mg HS; Valproic acid 180 TID; Trileptal; Scopolamine; Miralax

Data Discussion

Figures 1-4 display AA's SIB, tantrums, aggression and property destruction presented as percentage intervals he engages in the behaviors on school days using the measurement tool described. The behaviors all decreased some upon the initiation of Fentanyl, with further reductions seen when the tapering process for many of the other medications was complete on January 9, 2017. Figure 1 shows that SIB decreased less than the other behaviors, however, though the rate of occurrence was slightly lower, the classroom staff and AA's mother reported the behavior was much less intense and severe. Finally, at the end of each figure, a clear and immediate upward trend in the percentage intervals the behaviors occurred increased substantially, and the events were reported, and observed by this clinician to be more like those seen prior to medication changes.

The data suggest that Fentanyl and the tapering of several (listed in figure notes) medications are related to significant behavioral improvement during the period between approximately January 17 and the end of February, when an upward trend in the behaviors began. However, this analysis does not allow discernment of which variable(s) are most important, since Fentanyl and tapering were simultaneous—it is possible that AA's improvement was also, or solely, related to the withdraw of one or more of the discontinued medicines. Similarly, the recent uptrend in target behaviors, particularly with increased intensity including new tissue damage, may be related to acclimation to the Fentanyl dosage, or again, a delayed response to the withdraw of one of the other medicines that may have had some therapeutic benefit, though this was not evident before the introduction of Fentanyl. Lastly, it is possible this is a brief "relapse" (at the time of this writing) unrelated to medication changes.

FBA Summary and Recommendations

The FBA was unique due to AA's significant behavioral improvement as the assessment began. Nevertheless, the information gathered provides sufficient initial information regarding the variables related to AA's challenging behavior. The increase in target behaviors in early March allowed direct observation and interaction with AA during episodes of severe SIB, and aggression. Further, though limited, the recurrence of the severe episodes allowed direct assessment trials of functional variables and tests of potential intervention methods.

AA's challenging behavior appears to be influenced by several variables, including physiological variables and medical (medication) intervention.

The behaviors are more likely to occur under the following physiological conditions which may serve as setting events, or variables that make AA more sensitive to the environmental events that are also related to his behavior (described below). For example, when he is physically uncomfortable, he may be more likely to display SIB when a demand is presented compared to when he is feeling comfortable. The variables include:

- When constipated or following 2-3 days without a BM (this time period can be better specified when more data on BMs are gathered)
- When he displays symptoms of illness/cold symptoms.
- When his sleep is disturbed. This is by parent report. Data on sleep and its relationship to challenging behavior will better ascertain this and how and when to intervene with regard to his sleep routine.
- Pain without an identifiable source (reported by Mrs. CCCCC and Ms. BBBBB based on facial expressions, crying, SIB in the absence of other circumstances that may make the behavior more likely).

The behaviors appear more likely under the following conditions:

- When he cannot access a desired object/activity or event, or tangible reinforcement -- the behavior may occur because of a history of being given access to the desired object/activity following the behavior.
- When demands are presented. AA's behavior often results in escape from demands, particularly when the episodes require use if protective equipment.
- When he is alone, or specifically, alone in the sensory room and his "alone" time is terminated.
- When attention is made available when problem behavior occurs.
- When alone—however, target behaviors typically only occur when he is alone and appears in pain or discomfort, or is sleepy/fatigued.

The effects of the medication interventions are difficult to precisely discern for the reasons detailed in the Data Discussion section. Additional data collection will provide more, important information, regarding the benefit of the current medication regimen.

Ongoing and Additional Assessment Recommendations

1) Trial-based functional analysis: this is a relatively short running assessment where behavioral function can be ascertained in direct and controlled fashion. The assessment has been shown to yield reliable findings of behavioral function, similar to more traditional, lengthy, functional analyses. Further, it is appropriate for students with dangerous behavior because a session stops on the first occurrence of the behavior. A behavior analyst (BCBA) with training and experience with experimental functional analysis of self-injury should conduct/oversee this analysis.
2) A more direct assessment of C's preferences and reinforcers may reveal items useful for both skill acquisition and behavior intervention programming.
3) The five-minute partial interval recording tool should continue as the primary data collection instrument.
4) Begin to note dates when symptoms of illness are apparent on the interval recording data sheet.
5) AA's sleep and its relationship to behavioral episodes should be more thoroughly evaluated. Sleep should be measured either as precise hours slept, or using a scale based on family best approximation (e.g., 8-10 hours, 6-8 hours, 4-6 hours, <6 hours).

Considerations for Intervention

A behavior intervention plan should follow this assessment and include the following procedures with precise details for implementation:

Skill acquisition

1) Use noise from dropped hard objects (e.g., toy octopus with plastic feet, bead shaker, shape sorter, wooden pegs) as a reinforcer contingent on accurate responding, even when prompted. Prompt fading and increasing the criterion for reinforcement should occur as AA begins to respond more reliably and with less resistance.
2) Since most of AA's instruction requires hand over hand physical prompting, it is very important that the instructor orient their body such that they are positioned the same way as AA. The instructor's right hand should be used to prompt AA's right hand from his right side, without obscuring his vision.
3) The picture communication system should continue to be pursued with an increase in the number of daily trials and trials across several environment. A modified version of the Picture Exchange Communication with touch rather than a picture exchange seems appropriate.

Problem Behavior

1) Continue current use of protective equipment. The need for detailed documentation of each application of the equipment should be evaluated with the school nurse and special education administration.
2) Two, and some times, three adults should assist with diaper changes to maintain AA's safety and the safety of those changing him.
3) AA should receive non-contingent attention every 2-3 minutes at a moment when he is not displaying challenging behavior.
4) A behavior analyst (BCBA) with skills and experience evaluating medication efficacy using behavioral data should conduct ongoing assessment, including collaboration with medical professionals when necessary (e.g., data sharing)
5) When AA displays any of the following, instructional and classroom routine demands should be minimized and the rate of reinforcement increased:
    a. Appearance of sleepiness; if dozing, he should be allowed to rest in his chair or on a beanbag chair (unless otherwise indicated, for example as part of a sleep intervention).
    b. When his mother reports that his sleep was limited the previous night
    c. Appearance of illness: red or puffy eyes and rubbing eyes, nasal. discharge, weepy or crying without other target behaviors.
    d. Two to three days with no BM – current data collection will help make this more precise.
6) When low-intensity SIB occurs, such as very light head hits/taps, or tapping his helmet on the floor, do not respond and delay the delivery of any reinforcement for at least 30 seconds of the absence of the behaviors.

7) Require a simple mand (request) as AA indicates he wants something, such as access to the sensory room, or a toy. This can include a point toward the desired object/room, a hand off or touch of a blank picture card. This should be done throughout the day.
8) When AA engages in SIB or aggression occurs: a minimum of two adults should be available to block attempts of both behaviors, use Crisis Prevention and Intervention or similar crisis management techniques (if trained and certified) if necessary, followed by use of protective equipment, if the episodes escalates to the point that AA can no longer be protected with blocking.
9) Injuries should be evaluated and treated by the nurse.

In addition to the recommendations above, a session-by-session function and skill-based intervention should be considered. This type of session should be run multiple times daily and continuously evolve as AA's skills develop, requiring very close oversight. One example of this type of procedure is in the description in the Classroom Observations, Descriptive Functional Assessment and Interview section above, where a simple communicative exchange yielded an opportunity for AA to access or remain in a favored location and receive a favored item on multiple repeated trials. By handing the blank card to the clinician, AA "asked" for "my turn" with the favored objects, or to access the sensory room. This was done whether or not challenging behavior occurred. Repeated administration of such an intervention will be required to build this communicative replacement behavior. Given the dangerous and highly complex nature of AA's challenging behavior, this procedure should be developed and initiated by a senior level behavior analyst with extensive experience in the functional analysis and treatment of severe self-injury. The sessions should run with two people: the behavior analyst should work with Ms. BBBBB and/or a Registered Behavior Technician (RBT), a direct therapy level behavior analyst technician, training and implementing the procedures together. When the team is running the procedures with consistent proficiency under direct supervision, daily training in the absence of the supervising clinician can begin.

Please feel free to contact me with any questions.

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First Last, AbC, BCBA
Title/Role
Affiliation