

This book series brings leading researchers and clinicians together to collaborate on books that present current research-based evidence for specific treatments across a broad range of subject areas. These books not only identify evidence-based practices, but also practice-based evidence. Furthermore, each book identifies the gaps in knowledge for future research.

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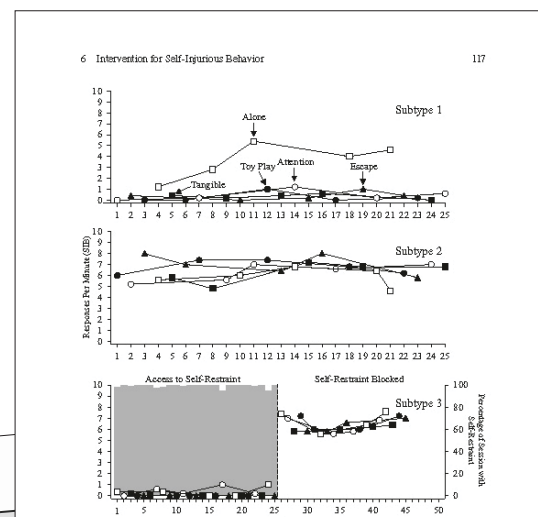


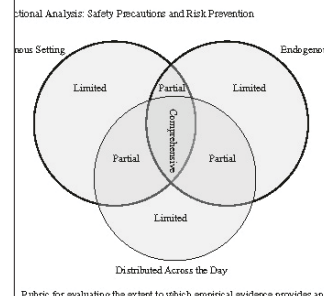
Fig. 6.2 A2/SIB subtype graph. minimized within the alone/ignore condition, conditions that test for social functions can be conducted with the sensory extinction or noncontingent reinforcement in place. If SIB is elevated in these social test conditions compared to the alone contact with sensory extinction or noncontingent reinforcement in place, it can be concluded that SIB also serves a social function. In addition, the rates of SIB between reinforcement intervals that exceeded those observed in the alone/ignore condition can serve as another indicator that SIB is multiply maintained (Cohenbauer et al., 2017). When evaluating multiply maintained SIB, it is essential to consider the safety implications of any equipment used to implement sensory extinction as well as the sense used for noncontingent reinforcement, especially if and when might be used to engage in SIB. In illustration, hand items should be avoided for item-to-head SIB.

Item	Category
Blank	Blank
Blue	Blue
Black	Black
Yellow	Yellow
Red	Red
Green	Green
Orange	Orange
Pink	Pink
White	White
Grey	Grey
Light Blue	Light Blue
Light Green	Light Green
Light Orange	Light Orange
Light Pink	Light Pink
Light Grey	Light Grey
Light Yellow	Light Yellow
Light Purple	Light Purple
Light Brown	Light Brown
Light Blue-Grey	Light Blue-Grey
Light Green-Grey	Light Green-Grey
Light Orange-Grey	Light Orange-Grey
Light Pink-Grey	Light Pink-Grey
Light Grey-Grey	Light Grey-Grey
Light Yellow-Grey	Light Yellow-Grey
Light Purple-Grey	Light Purple-Grey
Light Brown-Grey	Light Brown-Grey
Light Blue-Grey	Light Blue-Grey
Light Green-Grey	Light Green-Grey
Light Orange-Grey	Light Orange-Grey
Light Pink-Grey	Light Pink-Grey
Light Grey-Grey	Light Grey-Grey
Light Yellow-Grey	Light Yellow-Grey
Light Purple-Grey	Light Purple-Grey
Light Brown-Grey	Light Brown-Grey

Fig. 6.2 Severity and risk assessment. As a consideration when implementing PE, use provider protective equipment may be recommended for clinical safety (Rhee et al., 2013) although only a few studies have been conducted. Urban et al. (2011) evaluated the effects of teachers wearing shoulder-to-ear length pads under their clothes and baseball caps to protect themselves from hitting and/or pulling respectively in an 11-year-old boy with autism. Compared to a baseline (no equipment) phase, the pads and baseball cap reduced the frequency and severity of arm and wrist injuries. Linn et al. (2012) conducted an 11-year-old boy with autism who injured teachers by scratching the palms and back of their heads severe enough to cause abrasions, cuts, and bleeding. In addition, the teachers interacted with the boy without protective equipment. The baseline, the teachers interacted with the boy without protective equipment. The



Fig. 8.1 Average number of physical restraint and average minutes of physical restraint. Figure 8.1 (top panel) shows that during the baseline on average 11.0 minutes per day (range 3-12 minutes) were used for physical restraint. During the behavioral intervention phase, average time in PR decreased to 3.0 minutes per day (range = 0-10 minutes). Medication during the second intervention phase resulted in only 0.5 minutes per day (range = 0-1.0 minutes) per day. Physical restraint up periods had been eliminated. The bottom panel shows Dwyer demonstrated during baseline that 69.1% (range = 25-100%), 65.0% (range = 0-100%) during baseline, and 90.0% (range = 0-100%) during behavioral intervention. Summarizing the cases, frequent and long duration of systematic behavioral intervention



Roberts for evaluating the extent to which empirical evidence provides an indication of the generalizability of intervention programming. (Originally published in Plantinga, (Peters & Deuster, 2017) arrangement material for Linn et al., 2012) through sequential modification (O'Leary & Baer, 1977), a comparison from a randomized to a distributed-trial instructional format (see 1) for this systematic conditioning process can sometimes be bypassed for some learners, knowing whether, and which, generalization strategies will be employed at the onset of intervention informs safety considerations during the PE design process. For example, trial-based PAs (described below) might be the optimal approach when systematic generalization programs are not necessary or not feasible, and a distributed-trial-based intensive intervention format can be employed from the onset (Sundt et al., 2021). By contrast, for cases in which a session-based and mass-trial instruction in highly controlled settings will likely be necessary for generalization efforts, the safety advantages of conducting a trial-based PA will be offset by the need to conduct additional session-based baseline sessions after the analysis is completed (Lambert et al., 2012). For a rationale, see "PA as a Baseline" below.

**Efficient, Safe, and Useful Functional Analysis**

If a variety of research-based preventative measures have been employed and challenging behavior occurs nevertheless, clinicians should design PAs that most efficiently and safely obtain information necessary to formalize an effective intervention. PAs of challenging behaviors ultimately are useful in that they lead to effective treatment (utility), but they should be conducted with the safety of both clinicians

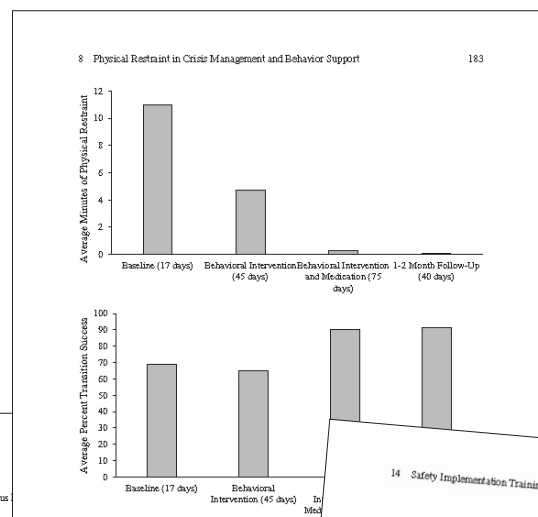


Fig. 14.2 Pyramidal training model. peers who then train other care providers (see Fig. 14.2; Parsons et al., 2013; Pence et al., 2014). This training approach was previously referred to as peer training (Pence & Shumway, 2009; Van den Pol et al., 1993). With pyramidal training, expert trainers are required to train both the protocol of interest and the procedures to train job training. First, the expert trainer must ensure that the peer trainer can accurately administer medication to the person served. If the peer trainer has not previously learned how to administer medication, the expert trainer should train the peer trainer to accurately administer medication. Once the peer trainer has not previously accurately administered medication, the expert trainer should train the peer trainer to use the BT to train other care providers how to administer medication. A competency out of interest and how to train others (i.e., they are ready to train the care provider to administer medication). Pyramidal training is beneficial to use in practice as more trainers are available, making it more cost and resource efficient for the organization. It also presents additional training opportunities for care providers to expand on their skills and obtain more responsibility. Additionally, research has shown that care providers demonstrated a higher percentage of protocol implementation when they were trained using pyramidal training rather than a consultant-led training (Haberlin et al., 2012). Pyramidal training has been used to teach care providers how to implement BT (Blackman et al., 2020; Conklin & Wallace, 2018; Esh et al., 2015, 2012; Parsons et al., 2013); functional analysis (Pence et al., 2014), responding to problematic behaviors (Conklin & Wallace, 2018; Shure et al., 1995), and sleeping procedures

Safety concerns are a priority among persons with intellectual and developmental disabilities (IDD) who may be susceptible to accidents and injuries, lack self-preservation skills that avoid hazardous exposure, and demonstrate harmful behavior such as self-abuse, aggression, and property destruction. Care providers also must be aware of personal safety when intervening physically with service recipients in crisis situations and on the basis of treatment plans. Within program settings, safety precautions extend to environmental care, staff training, and mitigation of workplace risk factors.

Research