

Functional Assessment

DEFINITIONS:

Functional Assessment

A Functional Assessment is a written report that generates working hypotheses about why specific behaviors occur (functional assessment involves correlations, thus “causal” statements are not possible). Methods to complete the functional assessment include record review, interviews, and information gathering assessments concerning specific behaviors. A functional assessment is used to develop a behavior support plan.

“We define FBA as a systemic process of identifying problem behaviors and events that (a) reliably predict occurrences and non-occurrence of those behaviors and (b) maintain the behaviors across time. The purpose of gathering this information is to improve the effectiveness, relevance, and efficiency of behavior support plans.”

---Online report by OSEP Center on Positive Behavioral Interventions and Supports: Effective school-wide interventions (technical assistance guide 1 Version 1.4.4, page 13). (12/01/99).

Functional Analysis

A functional analysis differs from a functional assessment in that it also involves the formal use of experimental design to test specific hypotheses regarding particular behaviors. Formal experience as a behavior analyst, appropriate consent, and HRC approval are needed to conduct a functional analysis.

“In cases where hypotheses are difficult to establish or where problem behavior is particularly resistant to intervention, functional ‘analysis’ may be recommended. A functional analysis involves systematic manipulation (i.e., removal and addition) of factors that are hypothesized as triggering or occasioning problem behavior. These manipulations are designed to trigger problem behavior under one set of conditions and not under others. However, in educational and clinical applications, we do not recommend functional analysis without the (a) direct involvement of an experienced behavior analyst, (b) consent and collaboration by families and caregivers, and (c) structures for maintaining appropriate accountability (e.g., data collection, monitoring of implementation fidelity).”

---Online report by OSEP Center on Positive Behavioral Interventions and Supports: Effective school-wide interventions (technical assistance guide 1 Version 1.4.4, page 15) (12/01/99).

OUTLINE for FUNCTIONAL ASSESSMENT

- A. Identifying Information
- B. Referral Question/Statement of Need/Resources Used for Functional Assessment
- C. Background Information
- D. Medical(Physical) Status
- E. Mental Health History
- F. Relevant Behavioral Treatment History/Review of Current BSP
- G. Results from Current Assessments
- H. Summary and Recommendations

A. Identifying Information

The first section of the Functional Assessment lists identifying information for the individual. The name of the individual, the date of birth (age), the date the functional assessment was completed, and the author of the functional assessment needs to be on every functional assessment. However, other identifying information may be useful, as suggested below:

- Address
- Residential Provider
- Case Manager

B. Referral Question/Statement of Need/Resources Used for Functional Assessment

This section of the Functional Assessment states what circumstances prompted the need for the Functional Assessment. A brief description of the referral process might include the following:

- Who made the referral
- What behavioral concerns are present
- How are behavioral concerns interfering with this person's development, independence, and/or life satisfaction
- What was used to inform the functional assessment (i.e., record review, structured assessments, behavioral observation, self-report information, etc.).

C. Background Information

This section of the Functional Assessment begins the process of record review that will identify possible setting events, antecedents, and consequences for both adaptive and maladaptive behaviors. The following sections of the functional assessment will continue this process. Information that should be addressed in this section is outlined below. If information for any of these sections, or for the following sections, is not available for your review/is conflicting in nature/questionable, it should be stated as such in the report and listed as a recommendation to the IDT to attempt to obtain the information. Information presented must be factual and meaningful in terms of behavioral problems.

- Description of the individual. This section should include a physical description of the person, his/her communication style, and person-centered planning information (i.e, personal needs, strengths, goals/aspirations, dislikes, etc.).
- Family History. This section presents pertinent family/social history. Important information includes who the family members are, the presence/quality/frequency of family relationships/supports, history of abuse/neglect, history of mental illness, substance abuse, or developmental disability, religious and/or cultural/ethnic affiliation.
- Developmental History. This section presents information concerning pregnancy, delivery, and developmental milestones. History related to developmental disability, physical illness/trauma, and mental illness or trauma is also presented in this section.
- Legal History. This section presents information regarding the person's history of incarceration, probation, or other relevant legal history that may be related to the person's problem behaviors.
- Cognitive, Adaptive, and Emotional Functioning. This section presents at least the most recent I.Q. test results, the most recent adaptive functioning results, learning style, and information related to emotional/psychological functioning that is available.
- Residential Placement History. This section presents residential placement/living arrangements for this person. Address when, where, and with whom the person lived throughout their life, along with what prompted any changes related to residence.
- Educational/Vocational History. This section gives background information related to the person's education, such as grade level completed and type of education (e.g., special education) that the person received or is receiving. If applicable, present the person's educational goals. Likewise, information is also presented regarding the person's vocational history, including current place of employment, type of work, settings, and vocational goals.
- Daily Activity/Current Skills Programs (ISP). This section presents the person's daily schedule as written and/or as it actually occurs. This section also

presents the current ISP goals and some statement about the person's progress of those goals (general). A review of the teaching methods that are currently being used to help the person achieve their goals is also useful.

D. Medical Status

This section presents the current multiaxial diagnosis for the individual. Give the names of the current physicians involved and the names their respective specialties. For the purposes of this assessment, present the date of the diagnosis and the name of the doctor making the diagnosis. Some diagnoses you find may not have all 5 axes, so report what is in the record only.

AXIS I

AXIS II

AXIS III

AXIS IV

AXIS V

Present any other medical history found in the record that may not be part of this multiaxial diagnosis here. Do not add to or change the diagnosis that you presented above. This section may also be used for hearing and vision, past mental illness diagnoses, past physical illness diagnoses that may be relevant, or other medical information that is relevant.

For the purposes of the functional assessment, special attention should be given to medical conditions that may be associated with pain or discomfort (e.g., menses, constipation, GERD, Migraines, etc.), or otherwise associated with behavioral problems (i.e. epilepsy, sleep apnea).

E. Mental Health History

This section presents relevant psychiatric history:

- The name of the current psychiatrist/physician/prescribing entity.
- List of past psychiatric hospitalizations (dates, places, what prompted the hospitalization, and outcome)
- History of and/or current psychotherapy or counseling the person is receiving, including the name of the provider of these services and current treatment goals and progress.
- Current psychotropic medications, including the name and dosage of the medications.
- Past psychotropic medications that have been tried. If you have a record as to why medication was discontinued include that information.

F. Relevant Behavioral Treatment History/Evaluation of the Current BSP

This section presents a review of behavioral interventions that have been tried in the past as well as a review of the current BSP. An example of information that may be considered for this section of the BSP is outlined below:

- Past behavioral interventions/procedures and the outcome of those interventions/procedures.
- Information related to the past assessment of behavioral function for target behaviors.
- A summary of the most recent BSP procedures and interventions.
- A summary of recent behavioral data (i.e., current frequency for both target behaviors and for replacement behaviors).

This review of past data/information related to behavioral treatment is not a peer review. Rather, a factual presentation of past treatment (including the current BSP, if there is one) is presented.

G. Results from Current Assessments

This section presents results from both structured and unstructured assessments of behavior and mental health screening assessments. Structured assessments are completed with familiar caregivers from multiple environments directly by the behavior consultant. This section of the Functional Assessment includes the following information:

- Operational definition of target behaviors that were assessed. State the current frequency, intensity/severity, and duration of each targeted behavior presented. State what method(s) were used to gather information concerning each target behavior, such as ABC data collection and/or ABC Analysis of incident report or behavior log information/data and/or interviews with staff.
- Results from structured behavioral assessments. When applicable, results for structured behavioral assessments should be presented in a summary table format, along with written explanation of the results for that measure. Examples of these types of assessments are presented below:
 - Questions About Behavioral Function (QABF)
 - Functional Assessment Interview (FAI)
 - Motivation Assessment Scale (MAS)
 - Functional Assessment Screening Tool (FAST)
 - Maladaptive Behavior Assessment (MBA)
 - Reinforcer Assessment Screening System (RASS), or other reinforcement/preference assessments
- Results from Mental Health Screening assessments/screening assessment for specific developmental disability. Please note that for many of these assessments the publisher of the assessment requires supervision by a licensed psychologist for interpretation. Some of these assessments are restricted tests under Indiana Code. When working under the supervision of a licensed psychologist, these screening tools may provide important information regarding the behavioral functioning of the individual. Examples of these screening tools are presented below:
 - Compulsive Behavior Checklist
 - Emotion Problems Scales (EPS)
 - Assessment of Dual Diagnosis (ADD)
 - Diagnostic Assessment Scale for the Severely Handicapped-II (DASH II)
 - The Childhood Autism Rating Scale (CARS)
 - Asperger Syndrome Diagnostic Scale (ASDS)
 - Dementia Scale for Down Syndrome (DSDS)
 - NonConvulsive Ictal Signs Checklist
 - Reiss Screen

- Direct Behavioral Observation in settings associated with the presence of the targeted behavior and in settings not associated with the presence of the targeted behavior.

H. Summary and Recommendations

This section starts with a summary of all relevant information and concludes with the current working hypothesis regarding targeted behaviors (case formulation). If there was a specific referral question for the functional assessment, it should be specifically answered here.

Next, include a recommendation section for the IDT. This section provides specific recommendations for the IDT regarding the individual. For example, these recommendations might include obtaining important case file information that was not available for review, ideas related to teaching methods for the individual, ideas for other types of assessment or services that may be needed or helpful for the individual, or any other recommendation to improve life for the individual that was noted during the process of gathering information for the functional assessment (e.g., adaptive equipment or communication devices after respective assessment).

Next, include a recommendation section for the proposed BSP. Or, it may be recommended here that a BSP is not needed and that other less restrictive interventions should be tried first. This section will present basic plans for the BSP such as what problem and replacement behaviors it will address, etc. This section is not to be redundant and spell out the entire BSP. In short, this section states what you intend to do to support this person behaviorally.

Finally, include a summary table (see next page) to organize the behavioral information you collected during the Functional Assessment. A summary table is helpful to future consultants and helpful to you as you write the BSP or as you consider whether the assessment needs revision at a later date. The last row in this summary table is for instructional purposes and would not be included in the functional assessment.

ABC Summary Chart for Challenging Behavior

ANTECEDENTS			BEHAVIOR	CONSEQUENCES
Setting Events (Slow Triggers)	Antecedents (Fast Triggers)	Antecedent Behaviors	Challenging Behavior	Maintaining Consequences
Defined as including any correlated (with data) significant intrinsic or external factors that regularly lower the threshold for the display of challenging behaviors. This may include environmental, social, or physiological factors that relate to the behavior. (Slow Triggers)	Defined as environmental events that immediately precede challenging behaviors (Fast Triggers)	Defined as specific behaviors that (name) may demonstrate just prior to a challenging behavior.	Challenging Behavior. Behaviors to decrease.	Defined as consequences that increase the likelihood of the challenging behavior to occur again.
LIST HERE (Environmental, social, or physiological factors) Examples include: Medical Conditions Medication Side-Effects Psychiatric Symptoms Environmental Factors (e.g., time of day, gender of staff, specific settings, etc.) Personal History (e.g., abuse history, temperament, etc.)	LIST HERE Examples include those things that have immediately preceded challenging behavior as identified in the functional assessment.	LIST HERE List these behaviors here	LIST HERE List challenging behavior here (e.g., physical aggression).	Examples include Attention Escape Non-Social (need for stimulation) Physical pain/discomfort Tangible items
Address in: ISP, recommendations to IDT, and/or prevention section of BSP as warranted. Some of these may in fact represent fast triggers.	Address in: Prevention section of BSP. These need to be avoided whenever possible. If these situations occur, they need to be dealt with immediately by caregiver. New skills may need to be taught to help the individual cope with these situations better.	Address in: Prevention (or possibly De-escalation) section of the BSP. Staff need to do something when antecedent behaviors are displayed to prevent challenging behaviors. In the long term, antecedent behaviors may be shaped to include more adaptive behaviors.	List in BSP definitions.	Hypothesized function listed in BSP. Function(s) of the behavior(s) should be considered for all sections of the BSP: Prevention; Replacement behaviors/Skills development; De-escalation; and crisis intervention.