Reed Martin and Invited Panelists Address Legal Implications of Changing Behavior at Orlando Workshop

By Gary M. Jackson
Florida Mental Health Institute
University of South Florida

Reed Martin, J. D., author of *Legal Challenges to Behavior Modification* and *Educating Handicapped Individuals*, stated at a February 10th FABA-sponsored workshop that it is the intent of the law to not give up on any handicapped individual. Martin indicated that the law is clear in regard to protecting the right of the handicapped to receive appropriate services. This point, as well as many legal issues relating to the handicapped, was made in a three hour presentation to 150 FABA workship attendees.

During the course of his presentation, Martin referred frequently to Public Law 94-142 (Education for all Handicapped Children Act). The law has become increasingly important since movement has occurred away from academic discussions of regulations toward regulated approaches. Refinements in the intent of the law have surfaced, with more than 450 legal decisions stemming from PL 94-142 alone. Familiarity with at least the basic intent of the law appears to be a necessity for those individuals providing services to the handicapped.

Martin, nationally recognized for his legal expertise in the area of behaviorally-based applications, provided an eloquent clarification of the marriage between applied behavior analysis and the law. According to Martin, applied behavior analysis is consonant with the law in at least four ways.

First of all, applied behavior analysis has a reputation for "reaching out" to everyone. Behaviorists are known for their frequently successful attempts at providing services to persons regardless of severity or multiplicity of problems. This is consistent with PL 94-142 which emphasizes that *all* handicapped individuals must be provided with appropriate services, with such services being provided up to the twenty-second birthday.

"Secondly," Martin said, "behavior analysis works to develop abilities, not to restrain them." The established approach toward the development and facilitation of appropriate behaviors is a long-standing one in applied behavior analysis. This is clearly consistent with the intent of the law which specifies the development of one's abilities.

Thirdly, the applied behavior analysis emphasis on the generalization of behavior is consistent with the legal emphasis on the provision of services to new environments. According to Martin, the lack of emphasis on generalization may be a contributing factor to the "revolving door" phenomenon.

Fourthly, according to the law, whatever is developed must be effective. A data-based approach, an integral component of applied behavior analysis, is obviously advantageous since an ineffective intervention may be identified rapidly and another approach taken. In addition, ongoing determinations of effectiveness open the door for accountability. The law requires such a sensitivity to results.

During the latter part of his presentation, Martin focused on legal trends, including trends based on the 9th and 14th amendments to the United States Constitution as well as various court decisions. Trends included the individualization and specificity of appropriate treatment, right to a written plan, and the establishment of appropriate treatment goals.

A major point raised by Martin was the right to refuse treatment, including the right to refuse medication. However, Martin indicated, treatment may be provided on an "emergency" basis. Martin stated that a "clinically demonstrable need to prevent irreversible deterioration," defines, in part, the term "emergency."

These issues were continued into the afternoon with a panel session chaired by Dr. Jerry Martin. Other panel members included Dr. Jon Bailey, Dr. Wendy Culler, David Rodgriquez, and Attorneys-at-Law Reed Martin and John Rossman. Following a discussion among panel members on the legality of providing treatment to the handicapped, questions were solicited from the audience. A sample of the 52 questions included the following:

1. Is corporal punishment legal in (a) public schools; (b) HRS Group and Foster Homes; (c) HRS Clients' natural home?
2. Under federal or state law, what rights do foster or group home parents and ICF/MR staff have regarding a client's education? Do they have the same rights as natural parents?
3. Does the HRS Manual, *Behavioral Programming and Management,* apply to HRS clients in public school settings?
4. Please address sexual activity, both homosexual and heterosexual, for sexually mature, yet legally incompetent adults whose legal guardians request that sexual activity not be allowed.
5. If a school age client is functioning well in residential treatment and it is felt that he should go back with his parents, yet his parents are unwilling to take him, what are his legal rights and what are the facilities' options?
6. What is the legal liability of a human services worker mandated

Message From The President

As I mentioned in the last issue of *FABA Quarterly*, one of my goals for this year was to make FABA a more visible organization during the entire year. You will read elsewhere in this issue about the recent workshops in Orlando. Both were huge successes and afforded FABA considerable exposure statewide. FABA members who did not attend missed a rare opportunity to attend high quality workshops at no expense. The first day featured noted attorney, Reed Martin, who captured the interest of the entire audience. FABA was fortunate to have co-sponsors for this day and the major role played by H.R.S. District VII Developmental Services staff members Jac Kopp and Mary Lynn Pollinger as well as that of Betty Howe of the Florida Diagnostic and Learning Resources System should not go overlooked. Without a good deal of teamwork and cooperation this workshop would have never reached fruition. The second-day workshop devoted to computers came about almost entirely through the efforts of Don Pittman and Jon Bailey. One of the strengths of our organization is the dedication of such members. We received so many compliments about the two-day workshop, that we are already considering doing the same thing at least once next year. We would

sincerly like to have your input on the idea.

Your Executive Committee met for a lively session during the workshops. Several things which occurred at this meeting should be of interest to you. First, we are in a healthy situation financially. This will allow us to move forward on a number of major projects including a spectacular Fall conference. At the meeting it was reported that the new membership directory should be on its way to you soon. We had considerable discussion about the need to increase the membership of FABA. There are large numbers of individuals in "behavioral" type jobs who have never heard of FABA or who are not FABA members. We need your help to bring these people into our organization. Efforts will be made to enlist the assistance of key FABA members around the state. We also discussed the printing of a membership brochure and will be moving ahead with that idea. Much of the remainder of our meeting was devoted to the forthcoming annual conference. You should know that it is scheduled for September 15-16, 1983 at the Hilton Inn Florida Center in Orlando. Don Pittman is Convention Chairperson and Maxin Reiss is Convention Program Chairperson. *Please* contact

them with your ideas for the convention. We want an annual meeting which is responsive to our membership.

Lest you think that Don and Maxin are not moving ahead with plans for the annual conference, rest assured they are. In a planning meeting after the end of the workshop we formulated the outline of what will surely be an unprecedented state-level behavior analysis conference. Major speakers will be invited to address such areas as mental health, behavioral medicine, psychotropic medication, severe maladaptive behavior, and behavioral community psychology. Of course, it is too soon to know if we will be successful in attracting the people we want to invite; however, if you liked last year's conference, you haven't seen anything yet! One final word. Our 1982 FABA members have been slow in renewing their 1983 memberships. If you haven't done so, please do. At Fall conference registration time it will be much more "painful" to be a non-member than it has in the past. Do your part to support behavior analysis in Florida. Join FABA and encourage your behavioral colleagues to do likewise.

Jerry A. Martin
Sunland Center at Orlando   FABA

From the Editors

Legal Implications *from page 1.*
by his/her administration to carry out a treatment program which the human services worker feels is unethical or abusive?
7. What, if any, legal responsibility does a parent have to follow through on habilitation programs implemented in a child's school or other habilitation setting?

Following the morning presentation by Reed Martin and the afternoon panel session, a hospitality hour was conducted. The hospitality hour presented the opportunity for the audience to interact with Reed Martin as well as other panel session participants.

As a final note, there were many

favorable reactions to the morning presentation and the afternoon panel session. In addition, many participants expressed satisfaction with the idea of having a mid-year conference, with hopes of having other mid-year conferences/presentations in the future.   FABA

Articles concerned with the workshop on Applications of Computers to Behavior Analysis will appear in the next issue.   FABA

TALK:
A Systematic Behavioral Program for Increasing Speech, Language, and Intelligence in Autistic and Nonverbal Children

By Philip W. Drash
Florida Mental Health Institute
University of South Florida

What is the TALK Program? TALK (*Training for Acceleration of Language in Kids*) is a systematic and highly structured behavioral program for teaching speech, language and intellectual skills to nonverbal and verbally delayed children. The program has proven to be most successful with children six years of age and younger, but it can be used to increase the language development of any verbally deficient client. The program has also proven more effective with non-organically retarded children, but it has been successfully used with the neurologically impaired, such as children with Down's Syndrome or cerebral palsy.

How does the program work? The program consists of an Assessment Scale and Teaching Curriculum. *The Curriculum consists of 24 sequential* levels through which the child must progress. The curriculum begins at a language age of four months, and extends upward through a language age of six years. The level at which a child enters the curriculum is based upon a standardized assessment of the initial language age of the child. Each level of the curriculum has an operationally defined criterion. In order to move from one level of the curriculum to the next, the child must meet a criterion of two consecutive sessions of 80% correct or above. This procedure insures that the child has mastered all skills below the level on which he may be working.

The treatment program consists of systematically shaping desired speech in a standardized step-by-step fashion consistent with the language development curriculum. All of the standard behavior modification procedures for shaping behavior are used.

Children typically receive two, one-hour periods of therapy per day by behavior specialists trained in the operant conditioning of speech and language. Individual speech training is supplemented by a daily classroom program in which functional speech and language is stressed. The trainer provides written weekly guidelines to the teacher regarding the verbal level of the child and specific techniques to be used.

The typical treatment program extends for a period of six to eighteen months. The duration of treatment is dependent upon various factors including the initial chronological and language age of the child, the degree of language delay, the rate at which the child is progressing, and the presence or absence of other complicating behaviors such as negativism, aggression or self-injurious behavior.

Parents also receive training in techniques of language development to assist their child at home. However, due to the complexity of the techniques, parents are not expected to serve as the primary language therapists for their children.

Major components of the program include the following seven steps:
1. Reinforcement for any vocalization
2. Reinforcement for imitation of sounds
3. Reinforcement for imitation of single words
4. Reinforcement for spontaneous single word identification of objects
5. Conditioning imitative verbal chains
6. Reinforcement for functional use of verbal chains
7. Reinforcement for functional, normal use of speech

What is unique about this program? One of the major unique features of this program is that it provides an objective *Standardized Method for Evaluating Rate of Progress in Speech Training.* It is one of the few operant speech programs which uses rate as a basic datum. Both the data recording procedures and the activities of the therapist are highly standardized throughout the entire program. This standardization allows for precise analysis of the rate of progress the child is making at any point in time in comparison with national norms or with other children on the program. It also allows for cor-

Table 1. *Outline of Expressive Speech Development Curriculum*

Approximate Expressive* Language Age	Expressive Speech	Verbal Level
6 yrs or 72 mos	Complex Verbal Behavior	24
	Verbal Definition of 20 words	23
5 yrs or 60 mos	Visual Stimulus + Naming Response (ten 8 to 10 word sentences)	22
	Verbal Stimulus + Imitative Response (ten 8 to 10 word sentences)	21
4 yrs or 48 mos	Visual Stimulus + Naming Response (uses 1000 words) (ten 6 word sentences)	20
	Verbal Stimulus + Imitative Response (ten 6 word sentences)	19
42 mos	Visual Stimulus + Naming Response (ten 5 word sentences)	18
	Verbal Stimulus + Imitative Response (ten 5 word sentences)	17
3 yrs or 36 mos	Visual Stimulus + Naming Response (uses 600 words) (ten 4 word sentences)	16
	Verbal Stimulus + Imitative Response (ten 4 word sentences)	15
30 mos	Visual Stimulus + Naming Response (ten 3 word sentences)	14
	Verbal Stimulus + Imitative Response (ten 3 word sentences)	13
2 yrs or 24 mos	Visual Stimulus + Naming Response (uses 200 words) (ten 2 word phrases)	12
	Verbal Stimulus + Imitative Response (ten 2 word phrases)	11
20 mos	Visual Stimulus + Naming Response (40 pictures)	10
18 mos	Visual Stimulus + Naming Response (20 objects)	9
14 mos	Verbal Stimulus + Imitative Response (20 words)	8
1 yr or 12 mos	Vocal Stimulus + Imitative Response (12 sounds)	7
10 mos	Experimenter Imitates Child's Sounds — Child Repeats Sounds	6
6 mos	Vocal Stimulus + Any Vocal Response (6 sounds)	5
5 mos	Differential Reinforcement of Specific Sounds	4
4 mos	Reinforcement of Any Vocal Response (Babbling)	3
	Eye Contact in Response to Vocal Prompt	2
	(Motor Imitation: May be Omitted)	1

*The language age equivalents are extrapolated from the norms given in the Pediatrician's Handbook of Communication Disorders,[20] the Bayley Manual,[2] and the Binet Manual.[30]

rective action to be taken as soon as there is evidence a child is not progressing.

What are the Results of Treatment? For those children who respond to the program the results are highly consistent and the acceleration in the rate of speech and language development is quite rapid. Frequently the rate of speech acquisition is two to three times the rate of the normal child. The results every month in the program.

Gains in Intelligence. Because of the close relationship between speech, language, and intelligence, rapid gains in speech and language had a beneficial effect on intelligence. As shown in Table 2 the average IQ for nine children increased from IQ 49.7 to IQ 92.8 for an average gain of 43 points.

How Difficult is it to Conduct the Program? Any individual with basic knowledge of behavioral principles program. Workshops can be provided either at FMHI or at your own facility. For further information write or call:

Philip W. Drash, Ph.D.
Coordinator, Educational Services
Florida Mental Health Institute
University of South Florida
13301 North 30th Street
Tampa, FL 33612
Telephone (813) 974-4533

Table 2
GAINS IN SPEECH AND INTELLIGENCE FOR NINE CHILDREN

Initial Chronological Age	Initial Language Age	Final Language Age	Average Gain in Language Age	Months in Program	Average Rate of Gain in Language Age	Initial IQ	Final IQ	Average IQ Gain
4.0 yrs.	1.5 yrs.	3.9 yrs.	29 months	12 months	2.4 months for each month in Program	49.7	92.8	43.1 points

obtained with nine children are shown in Table 2.

The initial Language Age of the children was only 1.5 years. Some did not talk at all. After 12 months treatment the Language Age had increased to almost four years. The average gain was 29 months and the average rate of gain was 2.4 months of language for can conduct the program. We have trained a number of speech trainers who have had no previous experience in working with speech and language development.

How Can I Get More Information on the Program? FMHI provides regular training and workshops for those interested in learning more about this (Editor's Note: A workshop on how to use this program will be presented at the Southeastern Psychological Association Annual Meeting in Atlanta, Georgia on March 23, 1983. A summary was presented at the Second Annual Conference, Florida Association for Behavior Analysis in Tampa, Florida on September 25, 1982.) **FABA**

Experimental Design in Applied Settings

By Eb Blakely
Threshold, Inc., Orlando

The use of experimental designs has often been confined to the enigmatic research laboratory or to applied projects in which a multitude of behavior observers are used and events seem to transpire so smoothly. These situations often seem so far from reality that those in the applied area may be reluctant to use many of the methods described in the research literature, specifically, the experimental designs. The importance of designs in research settings is clear. The effect of the intervention (independent variable) must be validated if we are to use it with any confidence. Component analyses of the intervention can isolate the effective part of the procedure. Parametric analyses can help define the effective value of the treatment. The relative efficacy of two or more independent variables can be assessed using designs such as the alternating treatments design. All of these research activities contribute to the development and refinement of a precise behavioral technology that is so important.

Unfortunately, there is a paucity of experimental validation of treatments in many applied settings. Research design is often seen as incompatible with finding an effective treatment as quickly as possible. Ethical considerations may require us to take action without regard to careful analysis. Research design is not seen to benefit the target client, but only other clients, the literature, or the teacher/trainer who covets publications. However, without careful analysis, faulty conclusions may be drawn regarding the relevant independent variables. This can result in the implementation of inappropriate treatment strategies in the future.

The pragmatic problem is to maximize the use of careful analysis while addressing the problems inherent in applied situations (e.g., ethical considerations or expediency requirements by funding sources). This is not to suggest the use of rigid designs that inhibit flexibility and creative decision making. The goal should be one of making treatment decisions based on current

FABA Reviews New Book on Behavioral Geriatrics

As announced at the September FABA Conference, November of 1982 saw the publication of a valuable new book for those who work with the elderly and also for those who are interested in practical program evaluation strategies, particularly quasi-experimental approaches. *Overcoming Deficits of Aging - A Behavioral Approach* largely describes the development, implementation, and evaluation of both a day treatment and residential program for the elderly conducted at the Florida Mental Health Institute (FMHI) since 1975. As the title implies, the Gerontology Program has primarily followed an applied behavior analysis orientation; but, as the noted gerontologist, Dr. Eric Pfeiffer, has written in the Foreword to the book, "the authors have tried to integrate social, medical, and behavioral approaches, with an emphasis on behavioral methodologies."

This hardback book is 295 pages in length, features ten chapters all writ-

data rather than predetermined design characteristics.

One approach that can be used to achieve their goal is to implement an initial data system that will allow a maximum of flexibility for analysis. For example, baseline data could be collected on a target behavior and collateral behaviors or situations using only periodic opportunities for the data collection as in the multiple probe technique (Horner and Baer, 1978). This technique allows a multiple baseline analysis while avoiding continuous baseline recording for untreated behaviors or situations. If the multiple baseline becomes superfluous, a reversal could be implemented. The reversal condition can be brief (e.g., for an hour or day), if time or if ethical considerations preclude extended reversals.

When one is interested in the relative efficacy of two or more treatments, an *Alternating Treatments Design* (ATD) (Barlow and Hayes, 1979) can be implemented that can quickly demonstrate experimental control.

The basic feature of this design is the fairly rapid alternation of two or more different treatments or conditions, with each being associated with a distinct discriminative stimulus. Variations of the ATD design have been used since the 1960's, and it has been described under various names such as the *multielement baseline design,* the *multiple schedule design,* and the *simultaneous treatment design.*

The major advantages of the ATD design are that it does not require a withdrawal of treatment (which could reverse treatment gains) and that it allows the comparison of two treatments to be made more quickly than in a withdrawal design (Barlow and Hayes, 1979). In practice, the two treatment conditions can be alternated as rapidly, for example, as every two hours. The frequencies of the target response in each condition can then be compared to assess the relative effects of the conditions.

As previously mentioned, one aspect of the ATD design is that each condition is correlated with a distinct discriminative stimulus. An example of this with "rule sensitive clients" would be simply telling them which condition is in effect. With less sophisticated clients, other stimuli could be used, such as lights or colored paper. Such stimuli could be used only if the assumption can be made that the stimuli will not, by themselves, affect the data.

Another design, which builds on initial baseline observations and which is a variation of the multiple-baseline design, is the *Changing Criterion Design* (Hartman and Hall, 1976). In this design, the effect of an intervention is evaluated by repeatedly altering (changing) the criterion for reinforcement or punishment. Experimental control is demonstrated if the response rate changes as a function of the change in the criterion. The advantage of this design is that control can be demonstrated without treating collateral behaviors (as in a multiple baseline) or reversing therapeutic behavior change (as in a reversal). This design is particularly useful with clients whose behavior can come under the discriminative control of a rule such as "You will be reinforced if you do 50 situps or more.". With clients in which this discriminative control is not possible, an exteroceptive stimulus can be presented when the response requirement is met. An important point here is that the behavior should be free to vary above or below the criterion so that the stimulus control by the response requirement can be shown.

It is conceivable that all of the above options could be simultaneously available if the measurement systems for each are combined. For example, baseline data could be collected on a target behavior in two situations while two treatment procedures that manipulate two potentially relevant variables are implemented in other situations. This would essentially constitute a four component multiple schedule. Decisions could be made, based on the data, as to forthcoming strategies and analyses. The potential exists for implementing any of the aforementioned experimental designs.

In summary, experimental designs found in laboratory or well-funded applied research have not abounded in mainstream applied situations. In the latter situations, ethical considerations and expediency requirements often overshadow design issues. However, scientific analysis is important in making treatment decisions concerning behaviors that are important to the client. Efforts should be made to conduct productive analyses within the constraints of applied situations. The designs discussed above exemplify attempts to address some of the relevant issues confronting treatment projects in applied settings.

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(Editor's Note: Mr. Blakely is Program Director of Threshold, Inc., a school and residential treatment center for people with autism. This is an invited article that recapitulates the major points of a paper that he presented at FABA's Second Annual Conference last September.)

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ten by personnel affiliated with the FMHI Gerontology Program, and has comprehensive reference and index sections. The primary author is Roger L. Patterson and the co-authors are Larry W. Dupree, David A. Eberly, Gary M. Jackson, Michael J. O'Sullivan, Louis A. Penner, and Carla Dee Kelly. Many of the authors will be recognized by readers as FABA members

and most of them are still affiliated with the Florida Mental Health Institute where applied Gerontology research and innovative services for the elderly are continuing, although now under the aegis of Florida's University System. During the time that most of the research described in this book was conducted, FMHI was organizationally part of Florida's Department of Health and Rehabilitative Services.

This book provides a thorough description of modular skill acquisition training and single case behavioral treatment, the two primary treatment approaches used by this program which treated 840 clients over a period of five years and four months. The chapters are much better integrated than most multiple author texts in specialized areas of clinical psychology

Training Teachers to Use Contingency Management Procedures in Their Classrooms

By Jeannie Golden
University of North Carolina
at Greensville

The customary procedure for dealing with behavior management problems that arise in the classroom is to refer the problem child to a professional such as a school psychologist who then comes to the classroom, observes the child, and assists the teacher in setting up an intervention program. The assumption is that the school psychologist has special training and skills in behavior management techniques that can be used in helping the classroom teacher. This often creates problems for both the teacher and the school psychologist. Teachers will refer their most serious behavior problems, and usually only after they have already exhausted their own resources. The period of time after the referral is made until the school psychologist can observe the child and make recommendations often creates a serious problem for the teacher. Additionally, the teacher may feel that an outside observer is not in a position to accurately assess the situation and to determine the types of intervention strategies that may be most effective. This may be detrimental to the credibility and effectiveness of the psychologist.

An alternate approach would be to include courses in behavior management in teacher training programs to insure that teachers develop the skills they need to handle serious behavior problems that arise in the classroom. In one such course, entitled "Contingency Management in the Classroom", special education teachers successfully implemented contingency management programs in their own classrooms with a variety of problem behaviors. Students enrolled in the course were first taught basic components involved in contingency management programming: direct observation and measurement of behavior, behavioral research designs, antecedents and consequences of behavior, principles of reinforcement and punishment, and intervention strategies, such as time-out, extinction, modeling, shaping, etc. They then each selected a single student from their classroom who was exhibiting a severe behavior problem, read about contingency management programs related to that problem behavior in journal articles, and wrote a proposed contingency management program. Upon approval from the instructor, the teachers began to take baseline data for the target behavior. They then implemented their intervention procedures, as they continued to record and graph data on a daily basis. Using an appropriate behavioral research design, they determined the effectiveness of the intervention strategy they had chosen, making necessary adjustments with the help of the instructor. Finally, students reported on their programs, displaying their graphs for the rest of the class.

Teachers were able to accurately identify and record incidences of problem behavior, with acceptable coefficients of interobserver reliability (ranging from .69 to 1.0, with a mean of .91). Having devised their own intervention strategies to eliminate these serious behavior problems, teachers in the course reported that they felt more confidence in their ability to control classroom behavior, used more positive procedures in dealing with management problems in general, devised

and they are sequenced in an interesting partially historic fashion which tempts the reader to want to first read the end to discover how it all comes out.

Suffice it to say that the program has been vigorously evaluated, both in terms of the effects attributed to individual program components and in terms of the impact of the overall program as measured by pre-post client changes during treatment and by the status of the clients one year after discharge. One particularly notable result from their evaluation strategy is found in Chapter 10. The authors report that 60 of 121 surviving residential clients from their Phase II Evaluation were able to be located one year after discharge. According to Penner, Eberly, and Patterson, "forty (66.7%) were in the community, 4 (6.7%) were in medical facilities, and 16 (26.7%) were in psychiatric facilities." To properly appreciate this statistic, the reader should know the following data tabulated on Phase II clients:

1) 35.5% were referred from state hospitals; 2) they had a number of 3.1 prior hospitalizations; and 3) 55.1% of them had been diagnosed as psychotic by the referring agencies.

There are criticisms that could be made of the program described in this book (as can and should be made of any pioneering therapy approaches on which data is still being collected), but there is little to criticize about this book. The writing is very clear and the data presented is more extensive than that found in most large service oriented applied research programs. In short, the authors have made a major contribution to the gerontology and therapy literature. This is a book which should be read by clinicians, State hospital administrators, and, particularly program planners in the areas of

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1983 Annual Meeting News

The Third Annual Meeting will be held at the Hilton Inn on International Drive in Orlando on Thursday., Sept. 15, and Fri., Sept. 16. The Inn offers a beautiful setting to conduct the conference and it is ideally located in the heart of Orlando's many attractions. The exciting program and terrific location provide a good opportunity for an excursion for the entire family.

The Program Committee, Maxin Reiss and Don Pittman, are working to make the 1983 conference bigger and better than ever. One of our primary goals for this year's conference is to broaden the program to reach into more areas of Applied Behavior Analysis. We're going to need your help. When the Call for Papers arrives in the Spring be sure to respond and submit your work.

If you would like to provide assistance at this conference or if you would like to make suggestions on planning

it, please write or call the appropriate person listed below:

Maxin Reiss, Ph.D.
Convention Program Chairperson
Behavior Mgt. Consultants, Inc.
1605 E. Plaza Dr.
Tallahassee, Florida 32308
Ph.: (904) 877-2534

Don Pittman, M.S.
Behavior Mgt. Consultants, Inc.
305 W. Par St.
Orlando, Florida 32804
Ph.: (305) 894-4270   FABA

Workshop on *Applications of Computers to Behavioral Analysis and Human Service Systems*--Observations of a Mental Health Professional

By Paula Hays
Mental Health Manpower
Development Program
Tampa, Florida

One of the first things which struck me at the workshop was that the preponderance of those attending were from the field of mental retardation. There were very few from the mental health field. In fact, a computer printout passed out early in the workshop day showed that thirty-three of the forty-one attendees which appeared on the printout were from the area of mental retardation; two were involved with mental health, both from children's programs.

One reason for the low attendance of mental health professionals may have been that mental health agencies were not well aware of the workshop. Another possible reason is that very few mental health programs, especially those dealing with adults, are behaviorally oriented in the strict sense and thus do not use or are not interested in behavioral analysis, at least the kind of behavior tabulating that is amenable to being put on a computer.

However, there were some presentations which I felt would have been of considerable value to mental health agencies.

For instance, Del Delaney, with the Developmental Services Program Office in HRS District VIII, gave a presentation in which he demonstrated a computer program which matched clients with specific needs and problem areas with the area's residential facilities which were equipped to deal with those needs and problems. The software package he used was *VisiFile,* a product of Visicorp. This type of program, in my opinion, could well be adapted to some aspects of case managing clients in the mental health system.

Dr. Robert Klepac, a psychologist at Florida State University, provided a handout entitled "Comparison of Selected Data Management Systems," enumerating the strengths and weaknesses of four software packages: pfs/FILE pfs/REPORT, VisiDex, DB Master, and The General Master. He demonstrated his use of his preferred software program, *The General Master,* put out by Sierra On-Line at around $230. This software has enabled him to compile a detailed resource file on the members of Academic Apple-Cations, which provides information services for psychologists using Apple computers. For information about this service, write to R.L. Klepac, Academic Apple-Cations, 3916 Leane Drive, Tallahassee, Florida, 32308.

The Beck Depression Inventory and the McGill Pain Questionnaire are on disc for the Apple II and can be ordered from Academic Apple-Cations.

It appears to me that a considerable amount of client information could be stored, utilized, and updated using such a software system.

The Computer Age is upon us, folks. We in mental health may need to do some catching up.

(Editor's Note: This is an invited article in which we wanted to get the perspective of a mental health professional on the content of the mid-year FABA workshop held in Orlando in February. In the next issue we will provide a further synopsis of this Computer Applications Workshop which will concentrate on the presentations by the two major out-of-state presenters. Paula Hays is the Tampa Area Coordinator of HRS's Mental Health Manpower Development Program. This was her first involvement with a FABA workshop. We certainly hope to hear more from her in the future. It is time for FABA to recruit more members from the field of Mental Health. FABA members, please share a copy of this newsletter with someone you know in the area of Mental Health.) **FABA**

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programs to manage problem behaviors throughout the entire classroom (by setting up point contract or token systems, for example), and began setting up individual programs for other students with more serious problems. One teacher of a severely and profoundly retarded class dealt with the hand-biting behavior of a student by using removal of sock covering and praise contingent upon nonhand-biting and a lound NO! followed by sock covering for each incident of hand-biting. By using a variable interval schedule of praise and gradually reducing the duration of sock covering, the teacher successfully eliminated hand-biting behavior, following a baseline in which hand-biting occurred in 46% of the intervals observed.

Another teacher of severely and profoundly retarded children was able to teach a student in her class to correctly name objects on picture cards, making appropriate discriminations when cards were presented in varying orders, instead of merely echoing the teacher's questions. She used pieces of graham crackers paired with praise and eventually faded the use of the crackers. Still another teacher enrolled in the course used squirts of juice and a pat on the leg paired with praise to eliminate out-of-seat behavior of a severely retarded child who stayed out of her seat throughout 21.2 minutes of her 30 minute music lesson. The head-slapping of a severely retarded child, who initially delivered an average of 27 blows to her head per minute, was drastically reduced by her teacher with the contingent use of verbal reinforcement and an overcorrection procedure. Another teacher employed reinforcement of toy handling and spontaneous verbalizations to decrease the nearly continuous mouthing of objects and people by a severely retarded child (from 97.6% to 33.5% of the intervals observed). These are just a few illustrative examples of the effectiveness of training teachers to use contingency management procedures in their own classrooms.

(Editor's Note: This is a summary of the presentation made by Dr. Golden at FABA's Second Annual Conference, September 23-24, Tampa.)

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community treatment and deinstitutionalization.

Reviewed by Bob Wehr
Florida State Hospital

(Editor's Note: Futher information on FMHI's Department of Aging and on the Gerontology Program described in this book can be obtained by writing or calling Dr. Roger Patterson, Director, Department of Aging, University of So. Florida, Florida Mental Health Institute, 13301 No. 30th St., Tampa, Florida, 33612 - Phone: (813) 974-4665. The book can be purchased from Plenum Publishing Corp., 233 Spring St., New York, N.Y. 10013, at a cost of $35.00 (Phone: 212-620-8000). **FABA**

APPLICATION FORM FOR MEMBERSHIP
IN FLORIDA ASSOCIATION FOR BEHAVIOR ANALYSIS

Name: ☐ Ms. ☐ Mr. ☐ Dr. _____

Check one of following:

Initial Application ☐

Membership Renewal ☐

Information Update ☐
  eg. change of address

Instructions for completing form: Wherever boxes are presented on this form, place check mark in the box which best describes your situation for purposes of accurate transfer to computer bank. This form may also be used for updating information on members for the annual FLORIDA DIRECTORY OF BEHAVIOR ANALYSTS and for renewing membership on an annual basis.

Highest Degree Earned: _____

from: _____ Major: _____

Home Address: _____ Hm. Ph.: ( ) _____   Preferred Mailing Address:

_____ ZIP _____   Home ☐   Business ☐

Bus. Address: _____ Bus. Ph.: ( ) _____   HRS Employee: Yes ☐ No ☐

_____ ZIP _____   Certified Psychologist
in Florida: Yes ☐ No ☐

Position Title: _____   Interest in writing for Newsletter: Yes ☐ No ☐

Institutional Affiliation:

☐ Corporation/Business
☐ Government
☐ Medical
☐ Pub./Priv. Educ. (0-12)
☐ Soc. Service/Retard./HRS/
   Men. Health/Fam. Services
☐ Student
☐ Univ./College Teacher
☐ Other _____

Check one:
☐ Full Member - $15

Special Interest Areas (Please rank order top five interests with "1" being top interest.)

___ Behav. Clin. Interventions
___ Behav. Commun. Psychology
___ Behav. Instruct. in High. Educ.
___ Behavioral Medicine
___ Behav. Observ., Assessment &
   Methodology
___ Developmental Disabilities
___ Behav. Pharmacology &
   Toxicology
___ Experimental Analysis
___ Private Practice
___ Behav. Anal. in Bus. & Indus.

___ Soc. Behav. & Soc. Skills
   Training
___ Verbal Behavior
___ Theoret. & Phil. Analysis
___ Educ. of Preschool &
   School-age Children
___ Women's Issues
___ Computers in Behav. Anal.
___ Legal & Ethical Issues
___ Gen. Issues in Behav. &
   Systems Analysis
___ Certification

☐ Student Member - $5 (You must be currently enrolled in a degree program in Florida.)

Send form along with check made out to "Florida Assoc. for Behavior Analysis" if you are applying for membership or renewing for calendar year beginning January 1, to:

Darrel Bostow, Ph.D. - FABA - 5210 E. 127th Ave. - Tampa, Fla. 33617

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FABA
5210 E. 127th Avenue
Tampa, Florida 33617