

Writing Comprehensive Behavioral Consultation Reports: Critical Elements

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Abstract

The accountability movement in psychology has resulted in practitioners increasingly using evidence-based interventions and treatment modalities to treat client problems. Behavioral consultation is one framework that practitioners can utilize in providing empirically supported services. In order to demonstrate the use of effective, evidence-based psychological practices, however, practitioners must carefully consider how they document their services and their outcomes. This article examines factors that practitioners must consider when writing reports on behavioral consultation cases. In addition, this article reviews 18 critical components that should be included in comprehensive behavioral consultation reports. Keywords: behavior consultation, reports, documentation, accountability.

Over the past several decades, clinical, counseling, and educational psychologists have been called to engage in indirect service provision due to the myriad unmet needs within the mental health field (Hayes, Barlow, Nelson-Gray, 1999). There remains a gap between the number of clients in need of mental health services and the number of practitioners trained to provide such services (Kataoka, Zhang, & Wells, 2002; Meyers & Nastasi, 1999). In parallel with the need for services to reach a greater number of clients, practitioners also have been faced with the challenge of demonstrating greater accountability in service provision. Specifically, recent movements within the fields of psychology and education have witnessed an increased focus on the use of evidence-based interventions and the documentation of treatment effectiveness and outcomes (Kazdin & Weisz, 2003; U.S. Department of Education, 2007).

Behavioral consultation is one approach practitioners can utilize to provide services through an empirically-supported delivery modality (Bergan & Kratochwill, 1990). The highly structured interviews that guide behavioral consultation facilitate transparent communication of data through written reports. For example, the three interviews that provide the foundation of behavioral consultation, including the Problem Identification Interview (PII), Problem Analysis Interview (PAI), and Treatment Evaluation Interview (TEI), can form the basis for written consultation reports. This approach facilitates the development of reports which serve to effectively and efficiently communicate assessment and treatment data with clients, serve as a source of hypotheses and interventions, and provide a baseline for evaluating progress and any future behavioral changes (Sattler, 2001). Further, the systematic and comprehensive documentation of treatment approaches and outcomes translates to increased accountability for practitioners.

The primary objective of this article is to provide readers with a review of critical components to include in behavioral consultation reports. To this end, we provide an overview of the steps of behavioral consultation, highlight best practices in report writing, discuss visual representation of data within reports, and we identify the critical elements of reporting through an analysis of a sample behavioral consultation report.

Behavioral Consultation Model

Behavioral consultation is a problem-solving process that includes four stages, problem identification, problem analysis, treatment implementation, and treatment evaluation (Bergan &

Kratochwill, 1990). Each stage is guided by a structured interview that is designed to facilitate effective communication between the consultant and consultee. Further, behavioral consultation is characterized by the use of standardized data collection procedures that enable meaningful inferences to be made about the effectiveness of treatments and interventions.

The first stage of behavior consultation, problem identification, focuses on accurately identifying the presenting problem. This stage guides the development of baseline data collection procedures, which in turn, effects treatment development and implementation. As such, it has been cited as the most critical stage of behavioral consultation (Kratochwill, Elliott, & Callan-Stoiber, 2002). The second stage of behavioral consultation is problem analysis, which focuses on identifying the conditions and variables that influence or maintain the identified behavior. By identifying the functional relationship between the problematic behavior, its antecedents, and its consequences, an intervention plan that alters this relationship can be developed (Kratochwill et al.). Third, the treatment implementation stage involves carrying out the intervention plan that was developed during problem analysis. This stage of consultation is further characterized by continual progress monitoring and treatment revisions (Kratochwill et al.). Finally, during the fourth stage of behavioral consultation, a formal treatment evaluation interview is completed to determine whether or not the goals of consultation have been met and the extent to which the treatment plan was effective (Bergan & Kratochwill, 1990). If the goals of consultation have been met, the behavioral consultation process and the intervention may be terminated; however, if the goals have not been met or new problems have emerged, the consultation process typically reverts back to the problem identification or analysis stage (Bergan & Kratochwill).

Considerations in Writing Behavioral Consultation Reports

In practice, consultation with parents and teachers often occurs informally. However, structured consultation approaches such as Bergan and Kratochwill's Behavior Consultation Model (1990) are more formalized and research indicates that adherence to the integrity of these procedures results in more positive treatment outcomes (Elliott & Busse, 1993). Clearly and accurately conveying the problem-solving steps taken across the three structured interviews (Problem Identification, Problem Analysis, Treatment Evaluation) is essential for purposes of accountability and documentation. Written reports that summarize these behavioral consultation steps are essential in the context of clinical practice. Yet, limited information exists within the literature about how to structure these reports or what to include.

In considering how to structure behavioral consultation reports, consideration of the literature on traditional report writing is useful. The literature is replete with guidance on report writing, with most of this focused on psychological assessment reports which involve detailed explanations of referral questions, background information, assessment tools, assessment findings, diagnostic conclusions, and implications for further assessment and treatment planning (Ownby, 1997; Sattler, 2001; Wolber & Crane, 2002). For example, Sattler (2001) overviews "19 Principles for Effective Report Writing" that emphasize on the need to consider one's audience, the purpose of the assessment, the theoretical framework guiding the interpretation of assessment findings, and the use of objective data to support claims and conclusions. The majority of these principles, however, are specific to psychological assessments using intellectual or achievement measures, and the direct application of these principles to behavioral consultation reports is limited.

The purpose of developing reports to summarize behavioral consultation services is to accurately convey the information that was gathered, to create a formal document that will help future service providers who might work with the client, to articulate consequential and antecedent behaviors that clearly link to solving a problem behavior, and to clearly demonstrate, via tables or graphs of baseline and treatment data, whether the goals of consultation have been met. It is essential that these aims be addressed through the use of written language that is objective and concise. In addition, the report should

clearly integrate the information gathered and the focus should be outcome-based. The framework to present this information should clearly link to the problems-solving model inherent within the behavioral consultation procedures and may include a framework such as those provided in Table 1.

Table 1 *Possible Behavioral Consultation Report Frameworks*

Section	Framework	
	A	B
1	Request for services/Problem statement	Identifying Information
2	Prior interventions	Reason for Referral
3	Student's strengths	Problem-Solving Techniques
4	Preliminary data collection	Background Information
5	Problem analysis	Problem Identification
6	Desired outcomes	Problem Analysis
7	Intervention Implementation	Treatment Implementation
8	Monitoring system	Treatment Evaluation
9	Follow-up session	Summary and Recommendations
10	Conclusions and Next Steps	

Visual Representation of Data

Perhaps the most important consideration in writing behavioral consultation reports is how to present dynamic data, or data that accurately represents the magnitude and direction of change over time. One method of organizing baseline and treatment implementation data is to create a graphic display for the purpose of illustrating trends in the client's performance over time (Upah & Tilly, 2002). Visual representations of data (e.g., graphs) concisely organize progress-monitoring data about changes in the client's performance levels from before treatment occurred until the end of treatment. In addition, the client's expected level of performance, or behavioral goal, can be represented on the graph, facilitating interpretation about the effectiveness of treatment. Using graphs to present progress-monitoring data also provides a measure of professional accountability by clearly demonstrating the behavioral change associated with the treatment being implemented (Upah & Tilly, 2002).

Using a standard graph format in reports facilitates the clear display and communication of dynamic data. When presenting data through a graph, the following elements must be included: (a) captions describing the measurement variables on the graph's axes, (b) scale units on the axes describing the range of the measurement, (c) points representing each instance of data collection (d) a goal or aim line, and (e) labels differentiating the baseline and treatment phases of the intervention (Upah & Tilly, 2002). Typically, the horizontal line (X-axis) of the graph is labeled to represent a measurement of time (e.g., sessions, weeks, school days) and the vertical line (Y-axis) of the graph is labeled to represent a performance measurement, (e.g., frequency, percentage, duration, latency, or rate

of the behavior). When labeling the scale units, each interval on both axes should represent the same unit of change. For example, if a target behavior is recorded weekly, then each interval on the horizontal axis is designated to be one week, and the range of the axis includes enough intervals to represent the entire duration of the treatment. A solid line connecting each data point is typically used to facilitate visual analysis of change over time.

When presenting both baseline and treatment data, data from the treatment phase is presented to the right of the baseline data to indicate that it occurred following baseline data collection. The behaviors recorded during baseline should be the same behaviors recorded during the treatment implementation stage. A vertical line is used to separate the two phases. When there are changes in treatment over the course of the consultation period, they are noted on the graph by drawing additional vertical lines at the times that these changes occur. Graphs should also include a goal line, which represents the expected level of behavior that the client will need to meet in order to meet the goal of consultation, or an aim line, which represents the rate of growth that a client must make in order to be considered a treatment responder (Cohen & Curtis, 2006). A goal line is formed by drawing a horizontal line across the treatment phase of the graph at the level of expected level of performance. An aim line is formed by drawing a line across the treatment phase of the graph between two points: a point indicating the average level of performance during baseline located on the vertical line separating the baseline and treatment phases and a point indicating the level of expected performance located at the last treatment interval.

Critical Elements in Behavioral Consultation Report Writing

Comprehensive behavioral consultation reports should summarize the problem-solving steps undertaken during the process of consultation and should synthesize the findings with a focus on client outcomes. In order to review the critical elements that comprise comprehensive behavioral consultation reports, a report exemplar based on the case study presented in Segool, Brinkman, & Carlson (2007) is provided along with a detailed analysis of 18 critical elements present in the report. This report is organized using the structural Framework B, which was presented in Table 1, and it contains notations indicating the location of the critical elements discussed below. This report exemplar is provided as a guide for developing comprehensive behavioral consultation reports, and it may be adapted to meet the specific aims of a report or the individual communication style of the report writer. While a report writer may adapt the organization of a behavioral consultation report, the writer should carefully review the report to ensure that the following critical elements are present in the report:

1. Identifying information: Provide relevant identifying information, including the names of the consultant, consultee, and client. The client's date of birth and age should be specified along with the dates of the consultation and the name of the organization sponsoring the consultation (Sattler, 2001).
2. Reason for referral: Provide specific information about the source of the consultation referral, the relationship between the consultee and the client, and the specific concerns that prompted the referral (Sattler, 2001).
3. Consent: Provide a specific statement that informed consent was obtained prior to beginning the consultation relationship. Ethical practice guidelines suggest that parties are informed of different treatment options available to them prior to beginning a therapeutic relationship (American Psychological Association, 2002).
4. Problem-solving Techniques: Specify all of the interviews and data-gathering procedures that were utilized during the consultation process. Identify the individuals responsible for carrying out data collection and the dates when each procedure occurred. The subsequent report should not simply be a

summary of the four behavioral consultation stages, but rather, it should coherently synthesize the information gathered throughout the consultation process (Bergan & Kratochwill, 1990; Sattler, 2001).

5. **Background Information:** Present pertinent information about the client's current functioning and any developmental history relevant to the referral concern using the Problem Identification Interview (PII) and other relevant sources of data (Sattler, 2001).

6. **Problem Identification:** Summarize the chief behavioral concern identified during the PII. Identify the need to collect baseline data about this concern in order to a) determine whether or not the problem exists as initially identified, b) determine the difference between the client's current behavior and the environmental or consultee's expectations, and c) further hypothesize about possible reasons for the client's behavior (Kratochwill et al., 2002).

7. **Data Collection Methodology:** Provide the operational definition of the target behavior to be monitored during baseline data collection in concrete and observable terms. Describe who will collect the data and how, when, and where the data will be collected (Upah & Tilly, 2002).

8. **Problem Analysis:** Integrate the findings from the Problem Analysis Interview (PAI) and the baseline data collection to describe what the functional relationship is between the target behavior, its antecedents, and its consequences. The goal of the problem analysis section is to provide an explanation as to why the behavior is occurring and to develop an intervention strategy (Bergan & Kratochwill, 1990).

9. **Baseline Data Presentation:** Provide a visual representation of the baseline data in the form of a table or a graph in order to aid the audience in interpreting the information. Refer to the "visual presentation of data" section to consider how data can be optimally organized and presented.

10. **Problem Definition:** The problem is defined as the discrepancy between the client's expected level of performance and the level at which the client is actually performing (Kratochwill et al.).

11. **Goal Definition:** The goal is defined as the level of behavior that is acceptable to the consultee. Goal development should include an analysis of the client's current behavior, realistic estimates of behavior change rates, and the time period covered by the treatment (Upah & Tilly, 2002).

12. **Treatment Implementation:** Provide a concise summary of the intervention that is designed to meet the goal definition. Identify who will do what, how, when, and where (Upah & Tilly, 2002). The consultant should refer to evidence-based practices in the research literature during the process of treatment development (Kazdin & Weisz, 2003). In addition, it is important for the consultant to consider the consultee's skill development during the process of treatment implementation and to provide the necessary training and support to the consultee so that she is able to implement the intervention with integrity, or as designed (Bergan & Kratochwill, 1990). In addition, the treatment implementation plan should include specific guidelines for data collection and ongoing progress monitoring over the course of the treatment implementation. In order to examine the impact of treatment, it is necessary to use data collection procedures that parallel the baseline data collection. Data should be collected at the same frequency, using the same unit of measurement, across the baseline and treatment phases of the consultation process (Bergan & Kratochwill, 1990).

13. **Summative Treatment Evaluation:** Provide a critical evaluation of the intervention effectiveness with respect to the problem and the goal definitions based on the Treatment Evaluation Interview (TEI) and the Progress Monitoring data. Identify whether or not the goal of consultation was met. If the goal of consultation was not met, the treatment evaluation stage is characterized by a reanalysis of the problem and definitions and by treatment revisions (Kratochwill et al., 2002). If the client is responding to the

intervention but has not yet met the goal, the consultee and the consultant may decide to reexamine the timeline associated with the goal definition (Bergan & Kratochwill, 1990; Upah & Tilly, 2002).

14. Progress Monitoring Data Presentation: Provide a visual representation of the data across the baseline and treatment stages of the consultation process. Clearly identify the goal line or the aim line in order to aid the audience in evaluating the behavioral change over time. Refer to the “visual presentation of data” section to consider how data can be optimally organized and presented.

15. Formative Treatment Evaluation: Provide a critical evaluation of the consultation process with respect to the relationship between the consultee and consultant, the problem-solving process, and the intervention design based on the TEI and other pertinent information gathered throughout the consultation process. Discuss whether or not the consultee found the process to be acceptable and feasible and discuss the current status of the consultation relationship (Upah & Tilly, 2002).

16. Summary: Provide a brief summary that integrates the information presented in the previous sections of the report, including the reason for referral, the problem identification, the problem validation through baseline data collection, the key elements of the treatment design, and the outcomes of the treatment (Sattler, 2001).

17. Recommendations: Provide specific recommendations to address any ongoing concerns about the client’s behavior. Specify what components, if any, of the treatment should be maintained in the future. Consider and address developmental or environmental factors that may impact the client’s behavior in the future (Sattler, 2001).

18. Signature: Following a thorough review of the behavioral consultation report to check for and correct any inaccuracies or typographical errors, the consultant should sign and date the original document.

Conclusions

Within clinical practice, careful attention to how one documents the process and outcomes of behavioral consultation is essential. Using clear and accessible language in reports to articulate the pertinent information gathered through the problem-solving process of behavioral consultation is one method for practitioners to demonstrate how they are accountable for their services and practice. As demonstrated within our report exemplar, the use of single-case design methodologies (e.g., baseline-treatment [A-B]) enables practitioners to efficiently evaluate treatment outcomes (Segool et al., 2007). Knowledge and effective communication of treatment outcome data is necessary for practitioners and clients to make data-based treatment decisions. Accurate visual representation of data provides an additional method by which practitioners can communicate treatment data to clients or other service providers. The critical elements reviewed in this article enhance communication between multiple stakeholders, including families, schools, physicians, and other mental health clinicians by making the behavioral consultation process transparent and clearly explaining both the process and outcomes of consultation.

Report Exemplar
Comprehensive Behavioral Consultation Report- Confidential

Client: Ashley Martin	Dates of Consultation: 04/05/2007 to 06/22/2007
Date of Birth: 01/01/2002	District/School: Springfield/Elementary
Age: 5 years, 3 months	Consultee: Arlene Martin
	Consultant: Jill Scott, PhD, School Psychologist

REASON FOR REFERRAL

Arlene Martin initiated contact with this psychologist on April 5, 2007 due to concerns about her daughter Ashley's extreme shyness and reticence with other children. Mrs. Martin indicated that she and her husband were hesitant about enrolling their daughter in kindergarten until she was able to be "more successful" with children in social situations. Mrs. Martin indicated a desire to help her daughter be more successful with her peers in formal and informal settings.

PROBLEM-SOLVING TECHNIQUES

This psychologist discussed different evidence-based problem-solving options with Mrs. Martin, including behavioral consultation, individualized behavioral therapy, and referral to a child psychiatrist. Mrs. Martin consented to participate in behavioral consultation with this psychologist due to her desire to provide support to her daughter in her natural environment. The following problem-solving techniques were used in the process of behavioral consultation and the findings are synthesized throughout this report:

Technique	Involved Parties	Date
Problem Identification Interview (PII)	Jill Scott, Consultant Arlene Martin, Consultee	4/12/2007
Functional Behavior Assessment (FBA)	Arlene Martin, Consultee	4/13/2007 to 4/25/2007
Problem Analysis Interview (PAI)	Jill Scott, Consultant Arlene Martin, Consultee	4/26/2007
Treatment Implementation (TI)	Arlene Martin, Consultee	4/27/2007 to 6/21/2007
Progress Monitoring (PM)	Arlene Martin, Consultee	4/27/2007 to 6/21/2007
Treatment Evaluation Interview (TEI)	Jill Scott, Consultant Arlene Martin, Consultee	6/22/2007

BACKGROUND INFORMATION

According to maternal report (PII), Ashley is a five-year, three-month old girl with typically developing language skills and no history of developmental delays. Within the home, Ashley is reported to be spontaneous, funny, and talkative with her father and mother. Outside of her nuclear family, Ashley reportedly does not initiate social interactions and she is reserved and withdrawn with other children. Ashley attends a 45-minute morning playgroup three days a week during which her mother reports that Ashley's shyness limits her from making friends and having new experiences. Ashley will respond to other children if they speak directly to her, however, she "tends to play around other children rather than with other children."

PROBLEM IDENTIFICATION

Following discussion of Ashley's typical behavior, Mrs. Martin identified Ashley's failure to

initiate social interactions with peers as her chief concern. Mrs. Martin indicated that she while she thought that Ashley had the skills necessary to be successful with peers, she was not certain of this because she typically provided scaffolding during the playgroup to get Ashley involved in play with other children, i.e. engaging in play with another child and then including Ashley in the game. Mrs. Martin reported that Ashley preferred playing with peers rather than alone, and that she frequently expressed a desire to make a “best friend” in the playgroup.

This psychologist and Mrs. Martin discussed the need to clarify Ashley’s current level of social interactions. Mrs. Martin agreed to monitor the frequency of Ashley’s social initiations during the playgroup by recording the number of times Ashley verbally initiated reciprocal interactions with peers for two weeks during every playgroup session. The *target behavior* was operationalized as any instance when Ashley spontaneously posed a question or made a statement that evoked a response from a peer (i.e., inviting a peer to join an activity or asking what a peer was doing). Events preceding and following any social initiation were also recorded and Mrs. Martin agreed to observe Ashley without engaging her during the play sessions.

PROBLEM ANALYSIS

Following data collection (FBA), this psychologist met with Mrs. Martin to review the baseline data, conduct a functional analysis of the behavior, establish goals for behavior change, and design a treatment plan (PAI). The baseline data revealed that Ashley only initiated interactions on two occasions over a period of six playtimes. Both times, she initiated play with a younger, four-year old girl, Sally who was described as quiet. Her peer responded positively each time and they played cooperatively for 5 to 10 minutes. No specific patterns of behavioral antecedents for Ashley initiating interactions emerged from the data; however, Ashley did demonstrate that she had the social skills necessary for having short, positive interactions with an individual child. Table 1 summarizes Mrs. Martin’s observations over the course of data collection.

Table 1: Baseline Functional Data

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
Initiations	0	1	1	0	0	0
With Whom		Sally	Sally			
Antecedents		Ashley watching Sally play with doll	Ashley clung to Mom. Told to play with a friend		Sally absent	
Consequences		10 minutes of play	5 minutes of play			

In discussing this baseline data, Ashley's mother expressed her belief that Ashley needed to have more comfort playing with other children in order to be successful in Kindergarten where she would be with a larger group of children. She felt that Ashley should be initiating a minimum of five social interactions during each playgroup session. Thus, the discrepancy between her actual behavior and the expected behavior was between 4 and 5 social interactions over a period of 45 minutes.

Mrs. Martin and this psychologist discussed possible intervention options that would provide positive support for Ashley to increase her rate of social interactions. Mrs. Martin agreed to an eight-week treatment plan that centered on using positive reinforcement and behavioral social skills training. The goal set for successful treatment was a stable increase in social interactions to five interactions every 45-minutes during playgroup.

TREATMENT IMPLEMENTATION

The treatment plan included four key elements:

- 1) Shaping and Social Skills Training- For the first two weeks of the intervention, Ashley's mother modeled how to initiate social interactions with children in multiple settings. During playgroup, Ashley's mother encouraged she encouraged Ashley to practice using her "Friendship" words, which included, "Hi!" "Do you want to play?" and "That looks like fun!"
- 2) Positive Reinforcement- Ashley received verbal praise, i.e. "You used nice friendship words!" or "Good going!" from her mother following every time instance that she initiated a social interaction with a peer. In addition, following each playgroup, a smiley face sticker chart was utilized to allow Ashley to monitor her progress. When Ashley met her goal of earning five smiley faces each day for five days, she received a predetermined reward (e.g., trip to Chuck-E-Cheese's).
- 3) Parent Training- Ashley's mother was encouraged to allow Ashley to play independently during playgroup. She discussed Ashley's progress with this psychologist in bi-weekly phone calls and the psychologist focused these conversations on explaining typical play skills of five-year-old children and encouraging Mrs. Martin to support Ashley's social independence.
- 4) Progress Monitoring- Mrs. Martin continued to collect data on Ashley's social initiations during playgroup times using the same technique as she used during baseline data collection. Because Ashley had expressed a desire to play with her peers,

TREATMENT EVALUATION

13 Following eight weeks of treatment implementation, Mrs. Martin and this psychologist met to evaluate the effectiveness of the intervention and to discuss the future of the consultation relationship (TEI). Mrs. Martin indicated that she was very satisfied with the outcome of the treatment implementation. She indicated that Ashley had made steady gains with respect to the frequency with which she initiated interactions with peers, she had met or exceeded her goal over the last three weeks of the intervention, and she frequently expressed pride in herself following playgroup, saying "Mom, I did great today!" Figure 1 summarizes Ashley's response to treatment.

14 Figure 1: Social Interactions over Baseline and Treatment

that Ashley will interact with, including the principal, secretaries, and teacher.

5) Contact this school psychologist to consent to monitoring Ashley's social interactions at recess and during unstructured playtime in the classroom if any future concerns arise.

Jill Scott, PhD
School Psychologist

Date

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