

Book Review

Supports Intensity Scale: Users Manual

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2004, x + 128 pages (plus one loose copy of No. 253, Supports Intensity Scale *Interview and Profile Form*, Adult Version), US\$95.00 (Manual only), US\$125.00 (Manual and 25 interview forms)

The development of an AAMR *Supports Intensity Scale* is a logical outgrowth of the American Association on Mental Retardation's (AAMR) emphasis on supports as being central to our understanding intellectually disability, as set out in the 2002 AAMR definition and classification manual (Luckasson et al., 2002). Just as AAMR's focus on adaptive behavior in the late 20th century was associated with the development of adaptive behavior scales, so too one consequence of AAMR's move toward a supports paradigm is the development of tools to measure support needs reliably and validly. The *Supports Intensity Scale* represents an important attempt to create such a tool. It focuses on the supports needed by adults with intellectual disability to participate fully in a wide range of aspects of life.

This spiral-bound *Users Manual* contains six chapters: (1) *Supports Intensity Scale (SIS)*: Context, Purpose, and Overview, (2) Administration of the *SIS*, (3) Scoring and Interpreting the *SIS*, (4) Using the *SIS* to Develop Individualized, Person-Centered Support Plans, (5) Potential Analyzes Using Aggregate *SIS* data, and (6) Technical properties of the *SIS*.

The Manual is clearly written throughout, and Chapter 1 provides a straightforward introduction to the concept of support needs and their assessment. One important section addresses the degree to which support needs differ from personal competence/adaptive behavior – both conceptually and in terms of how each is measured. The authors argue that personal competence is but one of several factors that influence support needs. They propose a three-pronged approach to measuring the support a person needs to be successful in various life activities, namely: *frequency*, *daily support time*, and *type of support*. Presumably, this approach was prompted by the difficulties of using a single measurement metric to evaluate support of varying intensity for different activities, some of which may be brief but fairly frequent (e.g., taking medications) and others of which may be less frequent but take much more time (e.g., shopping). The three-pronged approach taken appears eminently reasonable, although the relative weighting for scoring purposes of these three aspects of support may be the subject of debate and future research.

Chapter 2 clearly sets out how to administer the *SIS* by semistructured interview of one or more respondents (who may also include the person whose support needs are being assessed). The interviewer is responsible for synthesizing respondent's answers and selecting the most appropriate ratings. There are no specific, prescribed qualifications needed to administer the *SIS*. The Manual recommends that the scale should typically be administered by a professional with a degree, who works in the human service field and has several years of experience with people with intellectual disabilities.

Section 1 of the *SIS*, the *Support Needs Scale*, evaluates needed support in relation to 49 life activities organized into six activity subscales: (1) Home Living, (2) Community Living, (3) Lifelong Learning, (4) Employment, (5) Health and Safety, and (6) Social. All 49 items must be completed even if some items are not applicable or the person does not participate in the particular activity. *SIS* users may find it difficult to rate the *frequency* and *daily support time* for life activities that the person does not participate in. When another person is needed to complete the task for the individual with a disability, the *type of support* is rated as the maximal level of support (i.e., "full physical assistance").

In addition to the 49-item *Support Needs Scale* (Section 1), the *SIS* contains two other sections: the *Supplemental Protections and Advocacy Scale* (Section 2), and *Exceptional Medical and Behavioral Support Needs* (Section 3).

Standard scores are available for of the six activity subscales in Section 1 and a composite standard score is calculated from the six subscale scores to yield an overall *SIS Support Needs Index*, a continuous measure of support needs ranging from a low of 38 to a high of 150 (higher scores indicate the need for more support). These scores are said to be normally distributed with a mean of 100 and a standard deviation of 15 based on scores from a standardization sample of 1306 people with intellectual disability and related conditions from 33 US states and 2 Canadian provinces. Almost all sample members were adults (4% were aged less than 20 years). It was notable that women (56%) outnumbered men (44%) in this sample.

Sections 2 and 3 of the *SIS* are not used to calculate the *Support Needs Index*, even though these sections are clearly related to support needs. If significant support needs are identified in Section 3, readers are invited to "rely on clinical judgment and agency policy to incorporate the underestimation into the provision of supports" (p. 43). It is recommended that future editions of the scale will find a way to combine scores from all three sections into a single support needs index. The fact that this was not achieved in this initial edition points to the difficulty of so doing. It is also a reflection of the fact that there are individuals with unusual combinations of needs, especially in the areas of health and behavior, for whom the *SIS* (or any other support-needs assessment) may not provide an accurate reflection of support needs. Examples might include an individual with well developed adaptive skills but serious episodic mental health problems.

Scoring and interpretation are covered in Chapter 3 which deals with the interpretation of standard scores and percentiles from Section 1, as well as interpretation of the results from Sections 2 and 3. This chapter proposes several possible ways to relate *SIS Support Needs Index* scores to a classification system such as that presented in the 2002 AAMR

definition and classification manual (Luckasson et al., 2002), but none of the approaches outlined has any specific empiric basis. The information in Chapter 3 is supported by three detailed case studies illustrating varied real-life examples of SIS assessments.

Chapters 4 and 5, respectively, present individual and systemic applications of SIS assessments. The material on individual planning is complemented by examples of individual plans based on each of the three case studies provided in the previous chapter. The SIS can help place the focus on designing supports to enable the person to participate more fully in all aspects of life. However, it remains to be seen to what extent a *standardized* assessment such as the SIS will be perceived as useful within a *person-centered* planning context.

Suggested systemic applications include using aggregated SIS data to examine questions such as the relation between funding and support needs. An analysis of this issue for the field-test sample revealed that diagnosis of a psychiatric disorder, certain medical and behavioral needs (SIS Section 3), and selected items from the SIS Section 1 all contributed independently to the explanation of variations in funding. This finding accords with experience of the relation between funding and other measures of individual characteristics, where no single support-needs measure was found to be a sufficient predictor of expenditure on services and supports (Fortune et al., 2005). This finding means that readers will be disappointed if they expect the SIS to provide them with a single support-needs score on which they can base funding allocation. The Manual correctly identifies that such issues are complex, and that support needs are but one, albeit important, factor that should be considered in developing equitable systems for allocating funding.

Once important systemic issue that was not covered is the SIS's susceptibility to deliberate exaggeration or "gaming" to obtain higher funding levels in circumstances where SIS scores are used to help determine funding. The scale contains no internal checks for such bias. However, this is an issue that likely is more appropriately conceptualized as a systemic issue not just an assessment issue. The response to such bias may involve managing the assessment *process* (e.g., by involving independent assessors – see Fortune et al., 2005).

Chapter 6 on the SIS's technical properties reports that the six subscales in Section 1 have excellent internal consistency (range 0.91 to 0.99) and very good standard errors of measurement. Test-retest reliability was generally acceptable ($r = 0.79$ for the total SIS Section 1 score) or better, but interrater reliability was somewhat disappointing ($r = 0.54$ for the total SIS Section 1 score). No reliability data are reported for SIS Sections 2 and 3.

Evidence for content validity relates to a comprehensive literature review and Q-sort methodology used to sort items into domains/subtests. Item analysis revealed satisfactory item-total correlations of 0.53 to 0.82. Criterion-related validity was evaluated by having SIS raters rate each person's support needs on a 6-point scale before completing the

SIS. The correlation for the scale as a whole and these estimates was 0.62.

Adaptive behavior is strongly related to many lifestyle outcomes (Stancliffe & Lakin, 1998). Adaptive and challenging behavior have proven to be robust predictors of the cost of paid support (Fortune et al., 2005). The Manual reports correlation between SIS total scores and ICAP Service Scores to be $r = -0.49$, and -0.59 for the Vineland Adaptive Behavior Scales. The moderate size of these correlations lends support to the notion that the SIS measures a different construct from adaptive behavior.

The audience for this Manual is potentially large because it relates to a key issue arising from the supports paradigm: the nature and amount of support the person needs to participate fully in life. Therefore, the Manual will be of interest to advocates, service providers, clinicians, funders and policy makers involved in services and supports for adults with intellectual disability.

Overall this scale is a very sound first attempt at assessing support needs. The authors have reported their evaluation data openly, including the less complimentary findings, such as the modest interrater reliability. The major limitations are that the SIS currently only relates to adults, and that medical and behavioral issues are poorly integrated into the overall assessment of support needs. This is an issue of fundamental importance, and it seems certain that more research and development will be forthcoming, to enhance understanding of support needs and their assessment. Regardless of these limitations, I congratulate Thompson and colleagues on a fine job.

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