The Nicholas Center

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CLINICAL APPROACH

ENTRY TO THE PROGRAM

Here at the Nicholas Center, we believe in crafting services that truly match the values, dreams, and goals of the client. We understand that starting at the Nicholas Center can be an overwhelming experience for a participant that is not accustomed to our level of structure. Our “meet them where they are at” approach allows the participant to feel comfortable from the outset. For some, this may mean being fully integrated on day one. For others, it may mean starting within reinforcement for the majority of the day to establish the center as a fun and safe place. This immediately sends a message to the participant that they are understood. The participant can then systematically integrate into the program at their own pace. Our various program offerings allow us to create a customized experience for each and every participant.

We take time to thoroughly assess a participant prior to entry. This entails having the family and participant (if they are able and willing to do so) fill out the "Community-Life Plan" - Program Priorities document prior to starting. This document allows the clinician to analyze the main priorities and goals of the participant and their family via a rating scale. This exercise is followed by a series of questions lead by a member of the clinical team directed towards the family (See document entitled ‘Entry Interview Questions’ below).

ABA SERVICES

The Nicholas Center implements ethical and trauma-informed ABA services. In addition to conducting our inhouse FBA, clinicians take the time to learn about a participant’s history in part to lessen the risk of harm. This is done by collaborating with other service providers and maintaining regular communication with the participants family. We also take the time to listen to the voices of the autistic community. We accept feedback from our clients and their families. This allows us to merge their experience with the science of ABA in order to innovate, progress, and serve.

We understand that ABA can be an intrusive therapy. Safety for our staff and participants is our number one priority and always takes precedence over behavior correction procedures. An intervention that poses the risk of physical or mental harm to the participant, staff, or other participants is not a sound one. We always exercise parsimony and maintain a least-to-most approach. Often times, the best support we can give a participant is a simple environmental shift. ABA services are not always necessary and should only be considered if simple and logical explanations have been ruled out.

ABA services are only to be implemented if a behavior plan has been written and written consent has been gathered from the participant (if able) and the family. We avoid quick fix interventions (i.e. giving a participant a token board without proper review). We provide ongoing and extensive staff training on implementation and ethics, and we heavily critique areas such as dependency on escape extinction, edible reinforcers, and stim suppression. The behaviors targeted for change should be of social significance to the participant and their family.

Physical and vocal stims will only be targeted if they are causing potential harm to the participant or those around them. It is essential that if stims are a target, the participant is not feeling shamed for engaging in the acquired self-soothing mechanism. Rather, they are being taught how to cope in a more sustainable way that is safer for them and those around them. For integrity and health reasons, edible reinforcers should only be used in very rare cases and require clinical review (see section entitled 'Clinical Review Team' below) prior to implementation. We believe the implementation of escape extinction may cause a great deal of anguish to a participant in desperate desire of removing themselves from an aversive situation. It may also put other participants and staff in an unsafe situation. Therefore, we do everything in our power to avoid escape extinction and promote teaching and reinforcing appropriate alternatives to the escape-maintained behavior. If a clinician feels escape extinction is necessary, they require approval of the Clinical Review Team prior to implementation.

It is also important to note that we do not conduct functional analysis at the Nicholas Center as part of the FBA process. Although this enhances confidence in understanding the function maintaining a behavior, we are not equipped to purposely evoke behaviors of concern for experimental reasons.

INTERVENTIONS

We firmly believe in exhausting all possible reinforcement contingencies before considering a punishment procedure. If it is determined that a punishment procedure is necessary, the clinician must seek approval from the Clinical Review Team before implementing. Any extinction procedure should always be combined with reinforcement (DRA, etc.). If it is determined that a planned ignoring system is to be put in place, the participant should be informed ahead of time or during the behavior via a card system that we will be ignoring this behavior. All extinction and planned ignoring procedures must first be approved by the Clinical Review Team prior to implementation.

It is important to note that the majority of staff carrying out behavior analytic services will have little experience in ABA. The majority of the staff are also in 4:1 ratio and are on the move from our

in-house programs to our various community offerings throughout the day. Therefore, the interventions should be realistic to implement and simple to understand. Training and periodic supervision should be conducted prior to and during the implementation of behavior analytic services.

CONSENT AND PARENT TRAINING

If it is determined that a behavior plan is necessary, we firmly believe in involving the participant and their family in the planning and implementation process. The participant should be made aware of the intervention that is taking place and written consent should be attained from the participant or the family. Parent training executed by the Clinical Director or assigned RBT is encouraged to ensure generalization and consistency. This can be done at the participants home or over a video conference.

CLINICAL REVIEW TEAM

The Nicholas Center's Clinical Review Team is comprised of clinicians from various fields and backgrounds. The purpose of this team is to ensure that ethical practices are consistently implemented across the board. The team meets on a monthly basis and reviews any punishment or extinction procedures proposed to them by the Clinical Director. The group collectively decides via a voting system if they feel that the proposed intervention is sound and appropriate.

AGGRESSIVE BEHAVIOR

In the event a participant engages in aggressive behavior, participant and staff safety are our number one priority. Through proper assessment, we learn about aggressive behaviors prior to a participant entering the program. Sound interventions, staff action plans, and preventative strategies are then put into place. Staff action plans should entail the least physical contact possible, ideally none at all. While we are informed of SCIP procedures, as a community-based provider, our program or behavior plans are not written to formally implement SCIP or other restraint procedures formally. We take proactive measures to ensure the individual, those around them, and the environment is safe from further harm should an aggressive episode take place.

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ENTRY INTERVIEW QUESTIONS

The following questions are a part of the participants initial intake to the program. Every participant and family receive this interview prior to entry.

1) What are some of the individual's strengths and interests?

2) What are the participants and/or the families hopes and goals for being a part of this program?

3) Are there any particular areas that you would like to see addressed during the participants time at the Nicholas Center (for example, behaviors of concerns, skill deficits, etc.)?

4) FOLLOW UP TO 3: Have those behaviors been addressed previously? If so, what was done and was it successful?

5) Are there any personnel (behavior analyst, speech teacher, occupational therapist, etc.) that have worked with the participant that you would like for me to be in contact with?

6) Do you have any concerns regarding the individuals transition into the program?

7) Is there anything that you would like to share with us that we haven't covered?

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ABA SERVICE PROVIDER INTENTIONS

1. Promoting Positive Outcomes and Preventing Harm

How will you help me function better?

How will you help me do the things I want to do?

How will you help me learn the skills I want to learn?

How will you help me learn about the things that interest me?

How will you help me learn about my disability?

How will you help me be accepted?

2. Protecting Autonomy

How will you make sure I agree to the goals of therapy?

How will you make sure I agree to the methods you will use?

If I tell you that I don't want to do something during therapy, will you listen to me?

3. Being Inclusive

How will you help me be included?

How will you help address physical barriers I face?

How will you help address problem attitudes about disability?

Will you help me set healthy boundaries?

How will you support my communication and decisions?

4. Being Trauma-Sensitive

I have had some bad experiences in the past.

How will you help me with any therapy-related fears I have?

5. Promoting Cultural Competency

How will you respect my culture?

How will you help me participate in my family and community?

FUNCTIONAL BEHAVIOR ASSESSMENT

The follow pages are only to be used if it was determined that a behavior plan is necessary. Behavior Analytic services should not be provided until the FBA is complete and the behavior plan is written and signed by the participant or family.

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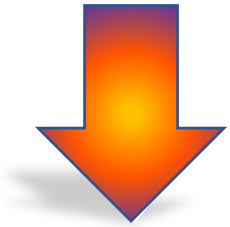
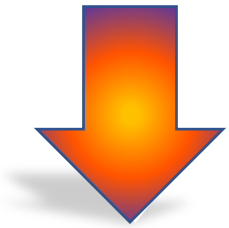
BEHAVIOR ASSESSMENT PROTOCOL OUTLINE

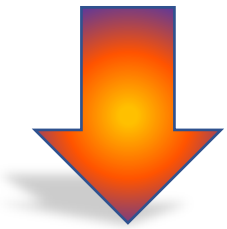
Step 1 – Interview



Step 2 – Direct Observation



Step 3 – Summary



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BEHAVIOR ASSESSMENT PROTOCOL

Step 1 – Interview

List of participants strengths and preferences (academics, employment, activities):

_____
_____
_____
_____

Description of the Behavior of Concern (what the behavior looks and sounds like):

_____
_____
_____
_____

Physiological and Medical Factors:

1) Could the behavior be the result of a medical condition or any form of physical discomfort?
   No ☐ Yes ☐

   _____
   _____
   _____
   _____

2) Could the behavior be related to a side effect of medication? ☐ No ☐ Yes

   _____
   _____
   _____
   _____

3) Could the behavior be the result of some physical deprivation condition (lack of rest, lack of sleep, etc.)? ☐ No ☐ Yes

   _____
   _____
   _____
   _____

4) Could the behavior be related to a traumatic event or any other past history of trauma?
   ☐ No ☐ Yes

   _____
   _____
   _____
   _____

Antecedent Events:

1) Are there circumstances in which the behavior ALWAYS occurs? ☐ No ☐ Yes

2) Are there circumstances in which the behavior NEVER occurs? ☐ No ☐ Yes

3) Does the behavior occur only (or more often) during particular activities? ☐ No ☐ Yes

4) Does the behavior occur with (or more likely with) certain people? ☐ No ☐ Yes

5) Does the behavior occur in response to certain stimuli (demands, termination of preferred activities, tone of voice, noise level, ignoring, change in routine, transitions, number of people in the room, etc.)? ☐ No ☐ Yes

6) Does the behavior occur in response to certain stimuli (demands, termination of preferred activities, tone of voice, noise level, ignoring, changing in routine, transitions, number of people in the room, etc.)? ☐ No ☐ Yes

7) Does the behavior occur only (or more likely) during a certain time of day?
☐ No ☐ Yes

Consequence Factors:

1) Does the behavior allow the participant to gain something?

   A. Preferred activities or items? ☐ No ☐ Yes

   _____
   _____
   _____
   _____

   B. Peer or adult attention? ☐ No ☐ Yes

   _____
   _____
   _____
   _____

2) Does the behavior allow the participant to postpone, avoid, or escape something such a task demands, social interactions, etc.? ☐ No ☐ Yes

   _____
   _____
   _____
   _____

   Does the behavior provide stimulation as an alternative to the participants lack of active engagement in activities? (when the participant is alone, has few known reinforcers in the area, another person is not responding/attending to the behavior) ☐ No ☐ Yes

   _____
   _____
   _____
   _____

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Step 2 – Direct Observation

The FBA interview results in a measurable description of the behavior of concern and information that leads to direct observation with data collection and analysis.

Behavior Definition:

Describe how often the behavior of concern occurs, how long it lasts, and at what intensity it occurs.

Describe any patterns to the occurrence of the behavior of concern (time of day, location, and others involved).

What antecedents are present when the behavior of concern occurs?

What consequences are present when the behavior of concern occurs?

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Step 3 – Summary

Hypothesis Regarding Function of the Behavior of Concern (the clinical team may identify more than one hypothesis)

If the behavior is hypothesized to be maintained by a history of trauma, please consult with other clinicians and do not proceed

1) When (antecedent to the behavior of concern) _____ (participant)

_____ (behavior of concern) _____

in order to (perceived function of the behavior)

_____

***Fill out below if behavior is perceived to be maintained by multiple functions)*

2) When (antecedent to the behavior of concern) _____ (participant)

_____ (behavior of concern) _____

in order to (perceived function of the behavior)

_____

3) When (antecedent to the behavior of concern) _____ (participant)

_____ (behavior of concern) _____

in order to (perceived function of the behavior)

_____

Description of Behavior Intervention Plan based off of the intervention results (must also be written on a separate sheet and signed by participant or guardian)

_____
_____
_____
_____
_____
_____
_____
_____