ACT’s Autism Manual for B.C.
Living and Working with Children and Adults with ASD

Chapter 2:
DEVELOPING A TREATMENT TEAM FOR A CHILD WITH ASD

Contributed by Jill Calder, MD, FRCP(C), Suzanne Jacobsen, Ed.D., Shannon Muir, MSLP(C), RSLP, Mary Ann Fulks, MSc, OT(C), with input from Kate Junaid, MSc, PT(C), and Beth Ott, MSc, PT(C), and Lianne Naguiat, BA, ECE
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The “Introduction to ACT’s Autism Manual for B.C.” provides valuable context to this chapter. Download at: www.actcommunity.ca/autism-manual.
DEVELOPING A TREATMENT TEAM FOR A CHILD WITH AUTISM SPECTRUM DISORDER

This chapter focuses on providing parents and community professionals with information on setting up a treatment team for a child with Autism Spectrum Disorder (ASD). To give an overview of the process and the key players, ACT has asked the following contributors to provide basic information as well as their perspectives. A key resource to read in conjunction with this chapter is A Parent’s Handbook: Your Guide to Autism Programs published by the Ministry of Children and Family Development (2015). See www.mcf.gov.bc.ca/autism/publications.htm.

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- Part B: The Role of the Behavior Consultant – Suzanne Jacobsen, Ed.D.
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- Part D: The Role of the Occupational Therapist and Physical Therapist – Mary Ann Fulks, MSc, OT(C), with input from Kate Junaid, MSc, PT(C), and Beth Ott, MSc, PT(C)
- Part E: The Role of the Behavior Interventionist – Lianne Naguiat, BA, ECE
PART A:
The Role of the Parent in Developing the Treatment Team

Contributed by Jill Calder, MD, FRCP(C)

Dr. Calder is a Medical Rehabilitation Specialist and Director of Rehabilitation Services at Royal Inland Hospital in Kamloops since 1991. In her clinical practice, she has special interests in pediatric rehabilitation and brain injury. Prior to qualifying as a doctor, she received a combined degree in occupational therapy and physical therapy. She has given numerous presentations on autism to medical and non-medical audiences, with a focus on the need for evidence-based treatment and interdisciplinary co-operation. Dr. Calder has an adult son with ASD.

Many parents attending Dr. Calder’s presentations report that they have been empowered by her core message that it takes all families time to absorb the reality of an autism diagnosis and move forward to form a treatment team for their child or children. Listening to Jill’s experience of her family’s path through diagnosis, to building a treatment team for her own son, many parents grappling with similar issues have come to realize that their own feelings of grief, guilt and exhaustion are all too normal. Most importantly, they come to realize how central they are to the process of developing a treatment approach that is individualized to their child and family needs. The key here is to individualize. Not all of Jill’s suggestions will fit every family’s circumstances but they may widen your perspective of how a family can engage in the treatment process.

“Like Google for Autism but Better!”

Throughout this chapter you will see AID links that connect to resources:
www.actcommunity.ca/aid-search/

ACT’s Autism Information Database (AID) has over 2000 autism-related information and community resources. It is easy to search using keywords and postal codes, which saves time in finding B.C. resources. There are links to excellent international websites on a wide range of topics relevant to children, youth and adults with ASD and their families, which community professionals may also find helpful. ACT’s staff has reviewed each of the resources we have included — our focus is on providing practical, useful resources that empower families and communities. Do you have a community resource to recommend for the AID? Go to www.actcommunity.ca/submit-resource/
In the early days, the multiplicity of appointments and the process of getting a diagnosis of Autism Spectrum Disorder for your child blend into a blur of what you “must do,” “should do,” or “should have done.” Frustration, overload, panic, and guilt are pretty typical of the feelings and reactions that parents experience.

From the 1950s to the 1970s, parents getting the overwhelming news that their child had autism were totally on their own, and were often blamed for their child’s symptoms. Those were the dark days when the spectre of the “Refrigerator Mother” dominated the autism diagnosis. By the early 1990s, it was accepted that autism was not the fault of parents, but there was still very little reliable information on treatment. Government services in British Columbia focused on providing respite so that parents could escape their child’s behaviors, not on helping parents learn what the behaviors meant nor on direct treatment of autism.

Two decades later, much has improved. It is accepted internationally that autism can be treated and in British Columbia there is government funding available—although many parents are challenged in using these funds effectively because of the shortage of professionals. While so much more is known about autism and so many myths have been debunked, the journey for a new parent is still daunting. In the early years there was too little information. Today many parents feel bombarded and suffer information overload. Many still feel utterly alone, carrying a huge responsibility that they feel ill prepared to shoulder.

It is my objective to reassure you that, with the help of the information in this manual and the other sources of support in British Columbia, you can manage your family’s journey to organize your child’s treatment and come to enjoy your child with autism as he or she grows and develops.

Why the Autism Journey is Unique

When you have a medical condition, you usually go to an accredited professional, learn about the disease, and get guided though a state-of-the-art treatment. Unfortunately, for those of us on the autism journey, there is immediate confusion. Autism Spectrum Disorder (ASD) is a medical condition—a neurobiological difference in the brain’s development in social, communication, and/or sensory system milestones. It is not the parent’s fault, nor is it the child’s. Yet there is no one centre of excellence or one category of professional that has all the answers for a parent trying to find treatment for their child with ASD.
In addition to needing to search outside of the medical model of disease and cure, parents experience a reality that each professional that will help along the journey comes and goes. One professional may be excellent for behavioral analysis and management, but not for language acquisition, or weak in an approach that focuses on the child’s social development. A professional may be knowledgeable for the early journey but not be experienced in guiding you during a child’s school years and helping to prepare for adulthood. Other professionals may be associated with a specific government ministry, and hard to get in combination with other professionals. Or you may have the challenge of living in an underserved community; the professionals with the skills in autism that you need may not be available in your home town when you require them.

At other times you will grow as a family and need a new consultant with a different style. Sometimes you need to take a break and re-group. It is during these times of transition that the constant people in a child’s life are their parents. Indeed, the parents are normally the constant throughout any child’s life. It took me a while to realize this; after three or four assessments, three or four consultants, I got it. I know my child best. I just needed to learn about this autism thing—and parent to my best level.

Looking back, I see three pieces that were necessary as I moved forward:

1. “Grieve my loss, but treat my child” – see “Stages and Styles of Grieving and Learning” below.
3. Get perspective and learn about ASD – see “A Brief History of Autism” and “Key References” at the end of this section.
Stages and Styles of Grieving and Learning

If you are in the early stages of having received a diagnosis for your child, you are likely grieving—losing the child that you thought you had. Similar to a death in the family, the process takes time and everyone has a different style. The process is not sequential: “First I grieve, and then I am perfectly functional again.” Instead you may experience more of a “grieve–function–grieve” cycle. I have dubbed this “constructive coping.” As long as the grieving is not the dominant phase day to day, things get done. If you are stuck in a depression or anger response, it does not help your child, so seek help for yourself.

Help means going to someone about you, not about your kid. Medications can help depression and anxiety symptoms (sleep disturbances, appetite change, low mood, poor concentration, sweats or panic). Talking therapeutically can help (special friend, family doctor, counselor, psychologist, psychiatrist, support group).

A Marital Survival Tip

If your spouse has a different style, don’t lord your newfound knowledge over them! Be especially careful to even up your partnership by reading some of the same things and going to some of the same events. Parents can use this as welcome break and attend a weekend workshop together! Autism Videos @ ACT (AVA), available for free are another great way to share information. See www.actcommunity.ca/videos. They can be watched together at your convenience on the family computer which makes them very adaptable to family schedules.

It is important to avoid a “mini-expert” mentality, as the less involved spouse can become alienated. Autism treatment is most effective for the child when both parents are generalizing it in the home environment—it is important to have both parents empowered. If only one parent can attend an event, see if the curriculum is available on DVD for the spouse who cannot attend or if there will be a online video. If only one parent can go, they can take notes and think of themselves as the scout looking for new ideas for the whole family.
Learning styles are just as variable as grieving styles and may change with the stages of grieving.

Here is one way of breaking down the various ways in which parents respond to the demands of parenting a child with ASD, while at the same time coming to terms with the shock of the diagnosis.

<table>
<thead>
<tr>
<th>Parent stage or style</th>
<th>More successful approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>THE GO-GETTER</td>
<td>Go ahead and read, but selectively and in a planned way. Autism will overwhelm even this enthusiasm. For a while I bought lots of books, but found I couldn’t put them into practical use until my child fit the stage of what the author was writing about.</td>
</tr>
<tr>
<td>OVERWHELMED</td>
<td>Read a little. Get the consultant to assist you in where to focus your attention. They can make the readings match the program and be practical for you to get into it. Explore whether you learn better when you attend workshops or watch a DVD or webcast on a topic rather than books.</td>
</tr>
<tr>
<td>PRACTICAL LEARNER</td>
<td>Search for a consultant to start on the case right away. See if there are any centre based programs in your community that have an expertise in autism treatment. Look for books that have a DVD to go with them so you can see how the therapy or approach works. Get some experience by watching videotapes of your child being treated. Many parents set up the camera so that they can watch later without distracting their child. The more the camera sits there on a corner on a tripod, the more the child will ignore it. The samples caught on tape can really help to see the style of interventions and the progress being made. Try out any recommended parenting style changes in your time with your child. Don’t think of it as therapy, think of it as living therapeutically!</td>
</tr>
<tr>
<td>OVERWHELMED BY GRIEF</td>
<td>Find a consultant who can organize much of the treatment team for you. Insert yourself back into the driver’s seat when you are more together. Get some help for yourself. You are not unusual in this style of grief.</td>
</tr>
</tbody>
</table>

“My reaction to my child’s diagnosis was to build an addition to the house. I thought, ‘If I am going to be a prisoner in my house at least I want a nice prison’. These less than effective reactions are just that — less than effective. Grieve gradually and gradually more effectively. You can meet the challenge of setting up a treatment program for your child but it takes time.”

Dr. Jill Calder
The Essence of Case Management

**What is Case Management?**

Case management is the effective co-ordination of assessments and treatments into a practical continuum of treatment and support individualized for the person with autism.

It is not fun or fair that parents must learn about autism, advocate, make money and run their child’s treatment team all at the same time. Yet there are advantages—the kids with actively involved parents often do better because the parent is more aware of their child’s needs. Not only that, treatment is less of a financial burden when you can effectively choose and tune the program to suit your child’s and your family’s needs.

Don’t expect to be a really effective case manager until you are six months to one year into setting up a treatment team for your child.

My analogy is sports. At first I felt I was in a sprint to the finish: to find the cure, the answers, whatever … but in a sprint you are all on your own, plus it is way too fast. So I slowed down and decided it was a marathon. However, in that analogy, you still think you can run the race by yourself. But in the autism game, you need a team!

Eventually I came to the analogy of football. American football—four plays for a 10 yard downs and lots of grinding ground game. At first I was just a player on the line, with everyone else coaching me. Eventually, I realized that I was outliving my coaches and players, I was a veteran, and in fact could call some plays.

Lately I think of myself as the “owner of the team”, and all those consultants play for me! I can decide who to put in to play quarterback for me, but I can also pull them out, even fire the team. I think the point is, that the play is for 10 yards at a time, and you need guidance to call some of the right plays, but you eventually march down the field.
Documentation and Communication

Binder:
- Pictures of child inserted front and back.
- Business cards, contacts pages.
- Active Program Summary or Individual Education Plan (IEP).
- Communication pages – recently thinned.
- Recent consults/assessments by discipline.
- Correspondence.
- Accounting for funding agencies.

File (retroactive or by year)
- Consults by discipline:
  - Psychology.
  - Education.
  - SLP.
  - OT, PT.
  - Medical.
- Program summaries, IEPs.
- Communication pages.
- Data and numbers.
- Accounting.

Communication Book:
- Light – thin pages frequently; current and active only.
- Any daily data.
- Program tools: social stories, cartoons.
- Calendar and schedules.
- Copy of Active Program Summary.
- Contact numbers.

All drawings by Dr. Bob Walter
Getting Organized

This is one of the biggest headaches of running a treatment program for your child with ASD, but it is easily solved. Buy a box, a binder, and get a picture of your child. The box is a banker’s size box, or hanging files—whatever system inspires you. The binder is no bigger than 1.5 inches, so not to sap your stamina as you lug it to meetings. The picture is to remind everyone at the meeting to keep their eye on your prize—your child. If you need to communicate with the school every day, a thin “to/from” book (aka a communication book) is helpful.

The Case Management Process

This focuses on picking a goal area, and developing a few measurable, accomplishable targets. You work along getting them started and done, revisit the list, and develop some more. Not rocket science really, but it does demand a bit of organization, and persistence! I find that three goal areas and three targets per area is enough to keep your child’s program moving along.

This cycle of getting assessed, developing targets, and working along to the next phase will take you through the diagnosis, the treatment and the support needs of organizing your child’s treatment program.
Developing the Team

Developing a circle of support, the “team” (although you may never have them all in the same room), takes time. There are professionals whose skills are honed to make the diagnosis, and there are professionals whose focus is more on treatment. Sometimes you can find someone who does both diagnosis and treatment, but don’t be surprised to find their limitations.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Training and Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior Consultant (BC)</td>
<td>ABA (Applied Behavior Analysis) training is a must. Must know and be well read in Lovaas, Fox, Schreibman, Koegel, Carbone, and other core behaviorists (see the end of this chapter for references.) Board Certified Behavior Analyst (BCBA) certification is a strong indicator of basic competency. See the ACT website (<a href="http://www.actcommunity.ca/rasp/information-for-families/">www.actcommunity.ca/rasp/information-for-families/</a>) for more information on choosing a behavior consultant, as well as the following section by Dr. Suzanne Jacobsen.</td>
</tr>
<tr>
<td>Behavior Interventionists/Therapists (BI)</td>
<td>Work under the guidance of a behavior consultant to implement treatment programs directly. Watch that you don’t sit back and think of these people as better with your child than you are! Learn their most effective techniques and adopt those that help in parenting your child. For tips on keeping BIs once you have invested in training them, see the end of this chapter, “The Role of the Behavior Interventionist.”</td>
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<tr>
<td>Speech-Language Pathologist (SLP)</td>
<td>Speech-Language Pathologists have expertise in language development but may not have specific experience with autism. However, those on the RASP do have at least 1 year of experience. It is very helpful if your SLP is current with the work of: Wetherby; Prizant (“SCERTS’ Model); the newest Hanen Program; Carbone, Sundberg, Partington (Verbal Behavior approach to ABA); Gutstein (Relationship Development Intervention approach to social cognition); and the work of Michelle Garcia Winner.</td>
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<tr>
<td>Occupational Therapist (OT)</td>
<td>OTs address age-appropriate functional living skills such as dressing, feeding, play, postures and positioning. They can assess motor skills, fine hand function and the function of the senses. Sensory Integration theory is useful when the child proves to have a problem in this area. It is a subspecialty for some OTs and they should be well read in the work of Ayres, Dunn, and research by Willbarger &amp; Willbarger. It is an advantage to be Sensory Integration certified.</td>
</tr>
<tr>
<td>Child Psychiatrist</td>
<td>Assists a behavioral or educational program with medication management of co-morbid symptoms of: anxiety, attention deficit, aggression, insomnia, and others. Do not think of medications as either good or bad. They can be blended in to help a program, but it is not advised that they be the only program. Data should be collected to objectively assess whether a medication is actually helping the targeted symptoms.</td>
</tr>
<tr>
<td>Professional</td>
<td>Description</td>
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</tr>
<tr>
<td>Educational Psychologist</td>
<td>Assists with a school-based team in academic modifications aimed at the assessed learning disabilities. School systems have workload problems and sometimes this professional is either not in the system or has a case load preventing adequate attention to every student. Hiring a private consultant and allowing the outside consultant to advise the school team can occur, but needs good inter-agency communication.</td>
</tr>
<tr>
<td>Nutritionist</td>
<td>Sometimes these kids have pretty weird diets, which can even be dangerous if it becomes too restrictive: carbohydrates only, soft only, peanut butter only – you name it. A nutritional review assures that basics are being provided. It is ideal if input from the nutritionist is coordinated with the OT and SLP for facial-oral sensory-motor issues.</td>
</tr>
<tr>
<td>Educator</td>
<td>This can be the preschool teacher, the classroom teacher or the principal. While one does not expect everyone to become an autism expert, they should have an understanding of the key points in assisting the child through all environments – this is the gold standard in care. Education systems have been under scrutiny for regular learners and special learners alike. While supporting educators as they work with your child is essential, parents may find they need to learn advocacy skills to help their child within the school system. For more information, see the chapter titled, “Navigating the B.C. Education System for Your Child with Special Needs – The Role of Parental Advocacy.” There is also an online video on advocacy available as an AID Resource: <a href="http://www.actcommunity.ca/resource/530/">www.actcommunity.ca/resource/530/</a>.</td>
</tr>
</tbody>
</table>
Tracking Progress

Develop a ledger, like a line-by-line entry chart, to track your progress. Put a date to things, because you will forget the order and priority from week to week. When a target gets accomplished, it feels good to check it off! After a while, the ledger is a useful chronology of where you started and how far you have come. It will help you gauge when your child’s program is stagnating and help you to focus on revitalizing the treatment approach.

The chart below is how I chart my son’s progress on a wide variety of skills, but you can adapt it to fit your own needs.

<table>
<thead>
<tr>
<th>TARGET: SKILL DEVELOPED, PROBLEM INTERVENTION, CASE MANAGEMENT</th>
<th>DATE</th>
<th>ACHIEVEMENT LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Achievement Levels:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not yet = not developmentally ready</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developing = earliest stage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working = increased proficiency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mastered = full skill level (compared to same age peer)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal Area: Classroom skills</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learn arm’s length rule for line ups, 90% of time or to same level as peers</td>
<td>Sep/98</td>
<td>Developing</td>
</tr>
<tr>
<td></td>
<td>Oct/98</td>
<td>Working</td>
</tr>
<tr>
<td></td>
<td>Nov/98</td>
<td>Mastered</td>
</tr>
<tr>
<td>Descend stairs safely for self and others, 100% of occurrences</td>
<td>Sep/98</td>
<td>Developing</td>
</tr>
<tr>
<td></td>
<td>Nov/98</td>
<td>Working</td>
</tr>
<tr>
<td></td>
<td>Ongoing</td>
<td>Working – nearly mastered</td>
</tr>
</tbody>
</table>

Down, set, hut…hut…hut….

For more information on program development and case management, attend one of the ACT workshops, join a support group, and get connected online. You can also search ACT’s Autism Information Database (AID) (www.actcommunity.ca/aid).

Understand that this information is only a starting point. It would be best to follow up with readings, workshops, parent support groups, and find a really good consultant, too! If your child is under 6, the Registry of Autism Service Providers (RASP) list is required to find professional support. (For important information on the RASP, see the “Role of the Behavior Interventionist” later in this chapter.)
A Brief History of Autism

When I received a diagnosis for my son, I realized I needed to have a bit of perspective to cope. Was I joining a well-oiled machine or a rickety horse-drawn carriage? In truth, the understanding of autism has come a long way, and I am glad we now have a biologic model and not the outdated “refrigerator mother” model of the 1950s.

The following timeline will give you an idea of where autism has been and some of the modern elements a program should have now. Autism is a moving target. The challenge, as with any other disorder that is getting so much attention, is to watch for new developments to get validated by research, and include them in your child’s program. Be on the crest of the wave and be wary of any stagnant programs.

| 1940s | **Leo Kanner** – 1943 – writes about a cluster of children whom he describes as having “infantile autism” - Boston.  
**Hans Asperger** – 1944 – writes about a cluster of children with verbal skills but social delays - Vienna.  
In the middle of World War II, autism is recognized on both sides of the Atlantic and the specialty of Pediatric Psychiatry is born. |
| 1950s | **“Refrigerator mother”** – the lack of bonding between mother and child is erroneously attributed to mothering style. Autism is widely held to be the result of poor parenting.  
Psychopathology principles in psychiatry are used to try and explain the observed behaviors in autism. |
| 1960s | **Measles** – outbreaks showed that babies from mothers who had measles while pregnant, had children with a spectrum of disabilities including autism. Autism was re-evaluated as potentially having biological causes.  
Behaviorists took on the toughest cases of self injurious behavior in people with autism and mental handicaps and showed that they could modify behavior, and teach more appropriate responses. |
| 1970s | **Ivar Lovaas & others** – developed “discrete trials” as a teaching methodology used on all children with developmental disabilities. This simple, step-by-step approach broke learning down into small components using clear instruction and rewards.  
**Applied Behavioral Analysis (ABA)** – this field of psychology is born from the work of behaviorists of the Sixties and Seventies. |
| **1980s** | Government agencies and the medical system lag behind the research. Only families near teaching and research centers received this structured learning program such as those developed by Professor Lovaas.  
Parallel developments were occurring in the SLP literature.  
1987 – Lovaas publishes ground-breaking research showing early intensive intervention could allow children to enter school with their peers. While overstating the results as a “cure” for autism, the results did challenge beliefs that these children were untreatable. |
| **1990s** | **Families and the lay press** – The publication in 1993 of Catherine Maurice’s book *Let Me Hear Your Voice* helped popularize Lovaas’s research among parents. A huge number of books came on the scene to get ABA out to families: Leaf & McEachen’s *Work in Progress*; Lear’s *Help Us Learn*; Freeman & Dake’s *Teach Me Language*; the publications list is long.  
By the end of the 1990s, parents and practitioners began to look at other issues in autism treatment, and make improvements on earlier work.  
**Generalization** – some of the early ABA programs taught skills that would be successful in one environment, with the tutor or therapist, but the child did not generalize to home, school or community. Getting the learning to occur in natural environments became an important goal.  
**Developmentally appropriate** – sometimes skills being taught were the easy, concrete skills, such as identifying complex shapes, ahead of schedule compared to the neuro-typical child. Later programs considered the important developmental milestones for the child.  
**Mind-blindness** – the idea that one of the key impairments is being able to hypothesize and take the perspective of another person.  
**Autism Spectrum Disorder** – by the late 90s, the variability from mild to severe, in each aspect of autism, social/sensory/language impairments, became a recognized feature of autism. |
Autism Research and Awareness Explodes!

Organized programs become available, but supply cannot meet the demand. Most of the programs and government policy changes come out of strong advocacy work by grassroots parent movements across the country, many of which are ongoing to present day. Most provinces adapt variations of ABA as their program gold-standard, but have difficulties developing the capacity of programs fast enough to meet the current needs. Diagnosis teams are developed improving recognition of ASD but the treatment teams continue to be a supply-demand crisis.

By the end of the 1990s and into the 2000s research in neurobiology is contributing to the understanding of autism and treatment programs are trying to keep up by addressing:

**Social Cognition** – programs started to address the social blindness that is a core feature of autism.

**Attention & Memory** – newer research is showing the attention to the “wrong parts” of the whole is a serious impairment in autism.

**Genetics** – research is confirming that autism is extremely complex. Some families are participating in multi-centre genetic studies.
PART B:
THE ROLE OF THE BEHAVIOR CONSULTANT
IN AUTISM TREATMENT

Contributed by Suzanne Jacobsen, Ed.D., BCBA

In British Columbia, the behavior consultant plays the leadership role in directing a treatment program for children under six, according to the rules set out by the Ministry of Children and Family Development (MCFD). Within four months of the child receiving funding, the behavior consultant should have developed a Behavior Plan of Intervention (BPI) based on the principles of Applied Behavior Analysis. For a child under six, it is essential that a family finds a behavior consultant who is on the Registry for Autism Service Providers (RASP) and who is a good fit for the family as well as being up-to-date in the field of autism treatment!

Keep in mind that the RASP listing for Behavior Consultants contains over 200 professionals (as of December 2015). Some have been more proactive than others in upgrading their qualifications. Ultimately, it is up to parents to make their choice. However, ACT does provide information on the website to help parents make informed choices.

For this manual, ACT has asked Dr. Suzanne Jacobsen to provide expert advice to families and community professionals on the role of the behavior consultant. Dr. Jacobsen has her doctorate in education and is a registered psychologist. She was one of the first behavior consultants in British Columbia to become a Board Certified Behavior Analyst and is a strong believer in the need for behavior consultants to be constantly updating their qualifications!

Many parents and professionals around B.C. have met Dr. Jacobsen in her previous role as an educational consultant for the Provincial Outreach Program for Autism and Related Disorders (POPARD). In addition she has diagnosed many children with a wide-range of special needs and has presented several workshops for ACT across our province, as well as internationally.
Developing a Treatment Team for a Child with ASD

One of the first tasks that a family faces when setting up a treatment team is finding a behavior consultant they will enjoy working with. I advise parents to interview two or three consultants before making their decision. A handy tool for doing this is “Talking to Professionals about their Qualifications,” written by Dr. David Batstone. See AID Resource www.actcommunity.ca/resource/2670/. I find that the parents who print this off before they come to speak with me are the ones who are best prepared.

When looking for a qualified behavior consultant for a person with Autism Spectrum Disorder (ASD), parents should ask for specific evidence of the consultant’s qualifications, and should expect to get a complete answer that makes sense. It is important to ask the consultant how they will help and what techniques and strategies they will use. If the consultant does not say they will use the methods listed below, ask them why not. If they do not have the training to use the procedures of Applied Behavior Analysis (ABA), you may consider finding a different consultant, one who has this kind of training, experience, and skills.

In the context of autism treatment in British Columbia, a behavior consultant usually refers to the person who writes the Behavior Plan of Intervention (BPI). Currently there is no regulatory body or College for behavior consultants in B.C., so anyone can call themselves a behavior consultant. While it is ultimately the parent’s decision who to hire, they can ask for help in understanding qualifications from ACT’s Information Officers and other community professionals. Many behavior consultants have voluntarily contributed profiles that are available on the ACT website and these are very useful in this process. See www.actcommunity.ca/rasp/search/. The individual behavior consultant record will indicate whether a profile is available or not.

Different service providers and agencies may use different names to identify a person acting as a behavior consultant including:

- Program manager.
- Case manager.
- Intervention manager/supervisor.
- Senior consultant/junior consultant, etc.
- Program supervisor.

Please be aware that only behavior consultants on the RASP are eligible to write a Behavior Plan of Intervention for children under six. For detailed information see A Parent’s Handbook: Your Guide to Autism Programs published by the Ministry of Children and Family Development. See AID resource www.actcommunity.ca/resource/377/.

The Next Steps Guide is a great resource to help parents put an intervention program in place for their child who has ASD: www.actcommunity.ca/resource/2083/. An online version of this resource can be found on the ACT website: www.actcommunity.ca/new-diagnosis-hub/. Also available in Chinese and Punjabi.
What are the qualifications of a Behavior Consultant?

Individuals with Autism Spectrum Disorder, their families, and other consumers have the right to know whether persons who claim to be qualified to direct ABA programs actually have the necessary competencies. All consumers also have the right to hold them accountable for providing quality services (e.g., to ask them to show how they use objective data to plan, implement, and evaluate the effectiveness of the interventions they use).

Skilled behavior consultants will have:

- A master’s or doctoral degree in ABA, or in a closely related discipline (e.g., psychology, special education, human development) with an emphasis on Applied Behavior Analysis or have a bachelor degree in the same disciplines and be directly supervised by an individual with these qualifications. Those who have experience in autism treatment but have qualified in other fields can become Board Certified Behavior Analysts. This way, families can be confident they have the prerequisites to work with children with ASD. (See the box “What is a Board Certified Behavior Analyst?”)

- Supervised experience implementing behavior analysis interventions for children and youth with ASD. This is a field where experience counts!

- A commitment to following the ethical principles of their professional association, whether or not they are licensed psychologists or a member of another professional discipline. Ethical practice requires professionals to provide only those services for which they have the appropriate training and experience.
Practices you should expect from a Behavior Consultant

In order to plan, direct and monitor effective intensive intervention programs for individuals with ASD, a behavior consultant must be competent in the following areas:

• Listening to family priorities and concerns.

• Observing the child or youth with ASD in their home or where they go to school, on a regular basis.

• Consulting with other professionals as needed, in a respectful manner.

• Developing a system for collecting objective data about the skills and needs of the child or youth with ASD.

• Creating a Behavior Plan of Intervention (BPI) focusing on specific developmental skills including:
  - Imitation.
  - Receptive and expressive language.
  - Fine motor abilities.
  - Academics.
  - Self-help & independence.

• Training behavior interventionists, parents/caregivers and school staff in implementation of the Behavior Plan of Intervention.

• Observing the treatment program being delivered and providing feedback.

• Modifying the BPI based on data collected from observing the child.

• Conducting functional assessments of problem behavior to determine why the problem occurs and developing an intervention plan based on the results of the assessment, in collaboration with the team, including the parents. The plan will address the factors in the person’s physical and social environments that contribute to the problem, and provide instruction on how to change those factors.

• Collaborating with other professionals including, for example, a psychiatrist if the person is receiving medication for the problem behavior or a psychologist who is conducting diagnostic assessments.
WHAT IS A BOARD CERTIFIED BEHAVIOR ANALYST?

A Board Certified Behavior Analyst is a behavior consultant who has documented graduate training and supervised hands-on experience in applied behavior analysis, and has passed a rigorous standardized examination in this area. This voluntary certification assures you that the professional has basic, general competency in ABA. However, it is up to the individual consumer to assess each BCBA’s/Consultant’s education and experience since some professionals may have completed only the minimum course work and experience to meet basic eligibility requirements.

The Behavior Analyst Certification Board offers certification for Behavior Analysts at the Bachelors and Masters/PhD levels. A Board Certified Behavior Analyst (BCBA) will have (at minimum) a master’s level education including graduate-level behavior analytic courses, approved supervised experience, and pass a standardized examination. Many BCBAs will have graduate degrees in Behavior Analysis, Psychology, or Special Education.

A Board Certified Assistant Behavior Analyst (BCaBA) will have (at minimum) a Bachelors degree including required behavior analytic course work, approved supervised experience, and pass a standardized examination. BCaBAs must work under the supervision of a BCBA.

These guidelines include recommended education/credentials/training/experience. See AID Resource [http://www.actcommunity.ca/resource/2180/](http://www.actcommunity.ca/resource/2180/). (Please refer to AID resource [www.actcommunity.ca/resource/663/](http://www.actcommunity.ca/resource/663/) for complete requirements for becoming a BCBA or BCaBA.)

The Autism Special Interest Group (SIG) of the Association for Behavior Analysis International asserts that all children and adults with autism and related disorders have the right to effective education and treatment based on the best available scientific evidence. Research has clearly documented the effectiveness of Applied Behavior Analysis (ABA) methods in the education and treatment of people with autism (e.g., Matson et al., 1996; Smith, 1996; New York Department of Health, 1999; U.S. Surgeon General, 1999)

PART C:
THE ROLE OF THE SPEECH-LANGUAGE PATHOLOGIST IN AUTISM TREATMENT

Contributed by Shannon Muir, MSLP(C), RSLP

Many people are puzzled about the precise role of a Speech-Language Pathologist (SLP) in general, let alone what an SLP can contribute to a treatment program for a child with Autism Spectrum Disorder (ASD), especially if the child can already speak. As many children with ASD have severe communication problems, an SLP can be an important member of the team. This is especially true if they have experience and specialized training in working with children with ASD.

To describe the different ways that an SLP can contribute, ACT has invited Shannon Muir to describe how they are trained and what they have to offer as a member of the treatment team. Shannon Muir graduated with a Master of Speech Language Pathology from the University of Alberta in Edmonton. She has worked in private practice since 1996 in British Columbia, supporting children and adults with ASD as well as other speech and language disorders. Shannon is a member of ACT’s Advisory Council and contributed to the British Columbia Autism Assessment Network (BCAAN) Standards and Guidelines for the Diagnosis of Children with ASD six and over.
The Basic Skill Set for Speech-Language Pathologists

All Speech-Language Pathologists receive training in how to assess, diagnose, and treat children and adults with all types of communication and swallowing disorders. However, very few universities offer courses on autism within their SLP programs. Once an SLP graduates from a university program, they gain work experience with specific populations, often seeking out training in that field. Some will work with a wide variety of ages and disorder types and some will work with very specific populations.

Specialization

Specialties can focus on:

- An age group: adults, preschoolers or school-age children.
- A specific disorder: autism, stroke, stuttering.
- A treatment approach, such as:
  - The Hanen Program (www.hanen.org).
  - Relationship Development Intervention (www.rdiconnect.com).
  - Social Thinking (www.actcommunity.ca/resource/715/).

Where SLPs Work

SLPs offer their expertise in a variety of environments. Some work in their own private practice, or as part of a private agency that provides contracted services. Others are salaried staff members of school districts, health units, hospitals or child development centres. At times, a family may hire an SLP to provide direct therapy to a child on a regular basis. This can happen in the family home, at a school or preschool, or in the SLP’s clinic. When there is more than one SLP working with a child, a co-therapy agreement must be developed and signed.

An SLP may recommend further consultation from a specialist SLP regarding an additional issue, such as swallowing problems or use of a communication device.

Some issues for which a specialist may be needed or your SLP may have additional training and experience:

- Augmentative and alternative communication.
- Swallowing problems.
- Apraxia or other motor speech disorders.
• Specific therapy methods for treatment of speech disorders (e.g., PROMPT, LIPS, Kaufman).

• Group therapy.

• Stuttering.

The type of SLP intervention used for a person with autism depends on:

• Their communication disorder(s) which often differ significantly between individuals on the spectrum.

• The stage of the child’s development: different types of intervention may become appropriate as the child matures or as the treatment or program develops or changes.

• The support system in place, including the involvement and skills of the family, the school team and whether or not they have other professionals involved.

• The specialized skills and interests of the SLP.

Possible Ways that an SLP Can Contribute to an Autism Treatment Program

The following are examples of ways in which an SLP can provide services for a person with autism. They are not mutually exclusive, but with limited funding available, families must often make choices about where the priority is in terms of using the skills of an SLP.

Direct Therapy with the Individual with ASD

Direct therapy is typically scheduled for a set block of time on a regular schedule, such as one hour per week. This direct therapy may address one or more problem areas depending on the child’s or youth’s assessed needs. These can include:

• Improving speech sounds.
• Broadening vocabulary.
• Comprehension.
• Developing grammar and sentences.
• Social use of language.
• Non-verbal communication.
• Reading.
• Writing.
• Problem solving.
• Swallowing/eating.
Direct Therapy Involving Family Members or Support Workers

This approach allows the SLP to model the therapy techniques and train someone else to continue that therapy throughout the day and week. This type of therapy often involves a support worker or family member doing some or all of the therapy during the session and the SLP giving suggestions and feedback so that techniques can be incorporated, learned, and corrected.

Consultation with the Autism Treatment Team

This approach involves the SLP working with the family and the professionals and para-professionals who support the person with ASD. This involvement can take several forms:

- Observing the person and making recommendations to the family or treatment team.
- Attending planning meetings at school, preschool, or with the home-based team.
- Providing written treatment plans, or working with other team members when planning activities and setting goals for the Behavior Intervention Plan.
- Modeling of therapy activities to team or family members.

Group Therapy

Groups can be used for treatment of communication problems. This may involve children/youth with ASD in a group with typical peers or a group of children/youth with ASD or other special needs. A common use of group therapy in autism is to focus on developing social skills and play skills. Group work provides opportunities for peer modeling, which can be very powerful, but individual therapy or consultation may be more appropriate for particular students or specific goals.

Education

SLPs who specialize in autism interventions can provide training, teach therapy techniques, and provide information sessions to families, caregivers, therapists, school teams, or other children.
Billing

Charges for services are set by the individual SLP or the agency the SLP works for.

The provincial organization, the BC Association of Speech Language Pathologists and Audiologists (BCASLPA) does not set guidelines for rates, but they can range anywhere from $110 to $140 per hour depending on experience and whether the SLP is in private practice or works for an agency. Each practitioner or agency will have different rates and policies for travel time, preparation time, telephone calls and report writing. Some SLPs work according to a “therapy hour,” which includes 45 minutes of direct therapy and 15 minutes of preparation time to support the direct therapy time.

Questions to ask your SLP

• Do you have extra training in autism or other approaches relevant to my child?

• Is there a specific type of therapy that you use?

• If so, is this a type of therapy that would be appropriate for my child? Why?

• Are you prepared to work with our home-based treatment program in some way? If so, what should I expect? If not, how do you communicate with the rest of the team?

• What is your hourly rate? What services do you charge for?

Frequently Asked Questions About Speech Therapy

1. What is the difference between a Speech-Language Pathologist and a Speech Therapist?

   Nothing, except that the first is the official title for our profession, and the second one is easier to pronounce!

2. What kind of service does my child with ASD need?

   Children with ASD are very individual and it is impossible to generalize. An assessment is required for the SLP to figure out the needs of the child and the approach that works best for the child and family. The answer to this question will change over time, as the child develops and learns more communication skills and as the treatment team evolves.
3. **What should I do if I am not satisfied with the services of my child’s SLP?**

Think about what you would like in your program. Be as specific as possible and ask your SLP, “Could you do this?” or ask your SLP for advice about the direction you want to go. Your SLP may have skills you are not aware of.

If you are still dissatisfied, tell your SLP that you think it is time for a change. Your SLP may be thinking the same thing and may even have suggestions for someone who would be a better fit. The SLP may be able to contact another SLP to make an introduction or find someone who has an opening.

4. **How can I find an SLP?**

- Check the Registry of Autism Service Providers on the ACT website for SLPs who specialize in autism treatment: [www.actcommunity.ca/rasp/search/](http://www.actcommunity.ca/rasp/search/). Remember, if your child is under six, you must choose someone from the RASP list if you plan to use provincial autism funding to pay your SLP. (If you find an SLP with experience in autism who is not on the RASP, and wants to be added, the application process is quite rapid.)

- You can also check the Private Practice List on the website for the B.C. Association of Speech-Language Pathologists ([www.bcaslpa.ca](http://www.bcaslpa.ca)) if your child is six or over or if you intend to pay privately.

- You may need to call several SLPs in your area to find one who has space in their schedule. If the SLP you want has no space, ask if he or she has a waitlist or when would be a good time to call back to see if a space has become available.

- Another valuable source of SLP’s, many of whom have experience in working with children with ASD, is through health centres and Child Development Centres. Children with ASD are eligible to receive these publicly funded services. However, if a child needs extensive SLP input, you may find that you require additional support outside the public system.
TRAINING AND QUALIFICATIONS OF SPEECH-LANGUAGE PATHOLOGISTS IN BRITISH COLUMBIA

SLPs trained in Canada must complete a Master’s Degree in Speech-Language Pathology. There are several Master’s degree programs in Canada. They all provide programs which train SLPs to assess, diagnose, and treat a wide variety of communication and swallowing disorders for both children and adults. In order to graduate, the student must complete coursework in key areas and complete practicum placements with supervised experience assessing and working with both children and adults.

SLPs must be an active registrant with the College of Speech and Hearing Health Professionals of British Columbia (CSHHPBC) which includes passing a certification examination administered through the Canadian Association of Speech Language Pathologists and Audiologists (CASLPA). To maintain registration, SLPs must complete regular continuing education requirements. Many SLPs are also certified by CASLPA and registered with the BC Association of Speech Language Pathologists and Audiologists (BCASLPA), however these memberships are not required.

SLPs educated and trained in the USA or other countries can also register in Canada by providing evidence to CSHHPBC that their training and education are equivalent to Canadian standards and those not registered in their home jurisdiction must pass the CASLPA certification exam.

All SLPs on the RASP are registered with the CSHHPBC.

All SLPs must work under a Code of Ethics, which states rules for working with each other, with other professionals, and providing services to individuals and families. To consult the code, see www.cshhpbc.org/docs/code%20of%20ethics.pdf?RD=1.
PART D:
THE ROLE OF OCCUPATIONAL & PHYSICAL THERAPISTS IN THE TREATMENT OF CHILDREN WITH ASD

Contributed by Mary-Ann Fulks, MSc, OT(C)
with input from Physical Therapists Kate Junaid and Beth Ott

As in the case of speech-language pathology, the role that occupational and physical therapists play in autism treatment can be very confusing for parents and indeed anyone who has not had experience of the range of services they offer. A helpful way of thinking about occupational therapy and autism is that the occupation of a child is play. However, for many children with an Autism Spectrum Disorder, it is hugely challenging to do all the things that a typical kid can do. This is where a skilled occupational therapist or a physical therapist can be very helpful, especially when they have additional training in sensory integration.

Mary-Ann Fulks is familiar to families and professionals across British Columbia from her presentations on behalf of ACT. Ms. Fulks is an occupational therapist with many years of experience in pediatric practice. She completed her sensory integration certification in 1990 and her Master of Science degree in Rehabilitation Sciences at the University of British Columbia (UBC) in 1996. Mary-Ann has worked in an early childhood mental health program where she often saw children with sensory processing issues. She has a private practice where she sees children with ASD and other diagnoses. She has been a clinical faculty member of the School of Rehabilitation Sciences at UBC and is a former member of the RASP Advisory Council.

Sensory processing is a term often used when discussing problems faced by children with ASD. This can refer to specific tests of sensory processing, observations of a child's sensory function, or the updated diagnostic label of “Sensory Processing Disorder” which includes a wider range of children and adults than those diagnosed with ASD. For more information on Sensory Processing Disorder see the website of the Sensory Processing Disorders Foundation at www.spdfoundation.net/.
Role of the Occupational Therapist

Assessing occupational performance for a child involves analyzing his or her functional or adaptive ability at home, preschool or school. It includes assessing a child’s motor skills, perception and sensory processing, and providing treatment and/or recommendations to address the issues.

A child with Autism Spectrum Disorder (ASD) may have a wide variety of issues for which an occupational therapist can provide support including:

• Eating/feeding concerns.
• Difficulties dressing, including tying shoelaces.
• Sensory-based behaviors including “meltdowns” triggered by over-stimulation for which calming routines may be developed.

In the preschool/school setting, an occupational therapist may provide support for difficulties a child faces with:

• Using a pencil, scissors or other motor skills.
• Coping with a group environment.
• Managing sensory-based behaviors including:
  - Sensitivity to noise or touch.
  - Self-stimulatory behaviors, for example, hand flapping.

An OT with experience and training in this area can help put together a sensory diet—a plan for sensory input at various times throughout the day to assist in the regulation of optimum levels of alertness.

Some occupational therapists have additional training and/or experience in working with children and youth on social skill development. This is particularly helpful for older children.

Professional Issues

Occupational therapists are required to maintain registration with the College of Occupational Therapists of British Columbia (COTBC), which regulates the practice of occupational therapy in B.C. and takes responsibility for “the safe, ethical and competent practice of occupational therapy in B.C.” Only those individuals who have completed training at an accredited university, passed the competency exam and have registered with the COTBC may call themselves an “occupational therapist.”

It is the responsibility of the occupational therapist to renew their registration on an annual basis and to practice in accordance with the ethical standards
and guidelines developed by the COTBC. Ongoing learning and education in order to keep abreast of new developments and evidence-based practice is a professional responsibility.

ACT ensures that all occupational therapists on the Registry of Autism Service Providers (RASP) are registered with the COTBC. Concerns about the practice of occupational therapists are dealt with by COTBC. Full information can be found at www.cotbc.org.

To practice occupational therapy in BC, individuals must have the appropriate educational credentials, pass a national certification exam, and maintain registration in the College of Occupational Therapists of BC (COTBC).

Until 2006, only a Bachelor of Occupational Therapy was required (and available from Canadian universities) to join the College. Since then, individuals are required to get a clinical master’s degree in order to practice: a Master of Occupational Therapy (MOT). Some individuals have pursued further education, which is an additional qualification, such as the UBC-based Master of Science degree (MSc), which focuses on research, or the online Master of Rehabilitation Science degree (MRSc), which focuses on enhanced practice. Other clinicians may have an additional qualification via post-graduate diplomas or other degrees.

Individuals practicing with a bachelor’s degree and registered with COTBC are well trained, many with years of experience and additional training through other courses and workshops in their particular areas of expertise.
Role of the Physical Therapist

The role of the physical therapist is to address a child’s gross motor performance. The physical therapist assesses mobility, gross motor skills and fitness. Underlying components that may be assessed include:

- Muscle tone.
- Posture.
- Coordination.
- Flexibility.
- Strength.
- Balance.
- Cardio-respiratory function.

A physical therapist may provide service to children with ASD because of:

- Delayed gross motor skills such as the inability to ride a bike or throw a ball.
- Challenges the child faces in being included in the pre-school or school situation in physical activities or in physical education classes.
- Poor physical fitness.

Professional Issues

Physical therapists are required to maintain registration with the College of Physical Therapists of British Columbia (CPTBC), which regulates the practice of physical therapy in BC. Only those individuals who have completed training at an accredited university, passed the competency exam and have registered with the CPTBC may call themselves a “physical therapist.”

It is the responsibility of the physical therapist to renew their registration on an annual basis and to practice in accordance with the ethical standards and guidelines developed by the CPTBC. Ongoing learning and education in order to keep abreast of new developments and evidence-based practice is a professional responsibility.

ACT ensures that any physical therapist on the RASP is registered with the CPTBC. Like the College of Occupational Therapists, it is the role of the College of Physical Therapists to address the public’s concerns about the practice of individual therapists. For more information see: http://cptbc.org/about-the-college/the-college/.

As of 2010, all new graduates from physical therapy programs in Canada were required to have a master’s degree (Master of Physical Therapy—MPT) in order to become registered with their governing provincial colleges (e.g.,
CPTBC) and practice the profession of physical therapy. The bachelor degree program previously offered was a comprehensive professional education and those who graduated are well trained and are registered with the CPTBC. Many of these individuals have years of experience and additional training through other courses and workshops in their particular areas of expertise.

**POSSIBLE WAYS THAT AN OCCUPATIONAL THERAPIST OR PHYSICAL THERAPIST CAN CONTRIBUTE TO AN AUTISM TREATMENT PROGRAM**

- **Direct Treatment** – The OT or PT sees the child at regular intervals (weekly, bi-weekly or monthly) and provide the treatment directly to the child.

- **Program Monitoring** – The OT or PT sets up a program which is carried out by others members of the intervention team, including parents, interventionists and teaching assistants. The program is periodically monitored with regard to its effectiveness and modified as needed. Many families find this a very cost-effective way to help generalize the input of occupational or physical therapy throughout the child's day.

- **Consultation** – The OT or PT may see a child only once or only very infrequently. An assessment is completed and recommendations are made.

**Role of the Parent in Contracting with an Occupational or Physical Therapist**

An important role of the parent who is considering involving either a physical or occupational therapist with their child’s program is to identify the concerns as clearly as possible. Often other members of the treatment team or the initial diagnostic assessment will have pointed to issues that could benefit from the involvement of an occupational or physical therapist. Sometimes it is a teacher who brings these issues to the attention of the parent but most often it is the parent themselves who sees the need but may not be sure who can help address them.

Once the parent has identified the issues, then the parent can interview prospective therapists. It is important to ask questions about the training and experience they have in dealing with the areas of concern. Not all occupational therapists have training in Sensory Integration. While not a necessary component for every child with ASD’s program, those who practice it should have specialized training.

It is helpful if the parent has clear expectations and communicates these to the therapist. Maintaining open communication as to the effectiveness of the treatment and programming or any other issue that may arise, is essential. Issues of payment for service, such as amount and frequency need to be discussed upfront, agreed upon and implemented. A written contract is highly recommended!
PART E:
THE ROLE OF BEHAVIOR INTERVENTIONISTS

Contributed by Lianne Naguiat

To find and keep competent behavior interventionists (BI) to work directly with their child is a constant struggle for families. Parents frequently complain that many of the BI’s they have hired and then trained are unreliable and leave shortly after their training is completed. For their part, BI’s often feel undervalued even though the contribution they make to implementing a child’s intervention program is critical. It is a difficult role to work with children with ASD in the family home, especially as most BIs are young and new to the workforce. Former ACT Information Officer Lianne Naguiat, who spent several years working as a Behavior Interventionist in B.C. and later as a Behavior Consultant in the U.S., shares her insights into retaining these essential para-professionals.

Ten Tips on Keeping a Good Behavior Interventionist

1. **BIs work better in a clean and organized work space.**
   Most of the time, their job may involve making a mess but BIs appreciate when their work area is tidy when they arrive. It makes running the programs more efficient, and they can be better prepared for therapy. Giving the BI time at the end of their shift to reorganize is very helpful.

2. **BIs look forward to your feedback before their shifts.**
   It is important for BIs to know how your child’s day went, how your child is feeling prior to their session, and any other relevant information. It is understandable that some days the parent is in a hurry to leave, but it really helps to communicate with the BI before they begin therapy.

3. **Try your best to maintain a regular schedule for shifts.**
   Your BIs commit their time to work with your child. Canceling or changing their schedule can disrupt their whole day’s schedule and make a serious difference to their monthly income. If you need to change or cancel a session, provide advanced notice to the BI, ideally at least 24 hours. This will provide a good example to the BI of the proper notice to give you of shift changes. If you can’t give notice, it is appreciated if you can pay them for the time they have committed to you.

4. **Cooperate with BIs in setting up reinforcers for your child.**
   Parents know their child’s preferences better than any other person. If your child’s reinforcers include specific edibles, BIs find it helpful when
you can set aside these edibles for them to use during their session. For reinforcers including toys or other tangibles, please also set these aside and have them available only during their shifts. It can be frustrating when BIs try to use a specific edible as a reinforcer, only to find out later on that your child has been eating it all day and is not motivated by it.

5. **Your BI also needs to be reinforced.**
   Be sensitive to what reinforces your BIs in order to increase their motivation and commitment. BIs must work hard to motivate your child and they generally appreciate it when parents make the effort to make them feel valued. Whether it’s a simple ‘thank you’ at the end of each shift, praise for them for the progress you see in your child, or a refreshment—these are all acts of appreciation that can encourage your BI to keep striving through the difficult patches.

6. **Be aware of your family matters that need to be kept confidential.**
   Although some BIs may consider themselves as a part of your family, be cautious of family interactions that need to remain private. This ensures professionalism and allows BIs to be comfortable in your home.

7. **BIs appreciate decent wages and being paid on time.**
   With today’s high cost of living, the minimum wage of $10.25/hour is too low. Because BI’s working hours are usually low, they should be paid every two weeks in accordance with the Employment Standards Act.

8. **Behavior Intervention ≠ Babysitting**
   Although many parents are grateful for the break that BIs can provide, they should not be considered as babysitters. BIs are there to provide behavior intervention to the child and the time they spend with the child should be considered as valuable time, not just an opportunity for parents to be able to run errands or leave their home. It is recommended that there always be another adult in the home with the BI.

9. **Consider BIs as professionals.**
   BIs may not be paid as highly as behavior consultants; but they are equally important in your child’s program. Consider BIs as crucial team players and professionals who deserve the same courtesy and treatment as you would give to any other professional. BIs need ongoing professional development and should be provided with opportunities for training.

10. **You are the BI’s employer.**
    In many cases, parents are the employers of BIs. As the employer, the parent has an essential role in ensuring the employee’s job satisfaction. Recognize that your BI also has personal needs such as wanting time off, flexible shifts, benefits, etc. Make sure you are sensitive to the needs of your BIs, just as you would want your employer to meet your needs.
Resources

Websites

- ACT – Autism Community Training: www.actcommunity.ca
- Autism Speaks: www.autismspeaks.org
- British Columbia Association of Speech-Language Pathologists and Audiologists: www.bcaslpa.ca
- Canadian Association of Speech-Language Pathologists and Audiologists: www.caslpa.ca
- Canadian Institute of Child Health: Moving and Growing: www.cich.ca/Publications_childdevelopment.html#movinggrowing1
  - “Moving and Growing”: Exercises and Activities for the First Two Years
  - “Moving and Growing” Exercises and Activities for the Twos, Threes, and Fours
  - “Moving and Growing” Exercises and Activities for the Fives and Sixes
- Canadian Institute of Health Research: www.cihr-irsc.gc.ca
- College of Speech and Hearing Health Professionals of British Columbia: www.cshhpbc.org/
- Hanen Centre: www.hanen.org
- Help Us Learn Training: www.helpuslearn.com
- Michelle Garcia Winner’s Centre for Social Thinking: www.socialthinking.com
- Relationship Development Intervention: www.rdiconnect.com
- Verbal Behavior: www.carboneclinic.com/resources
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