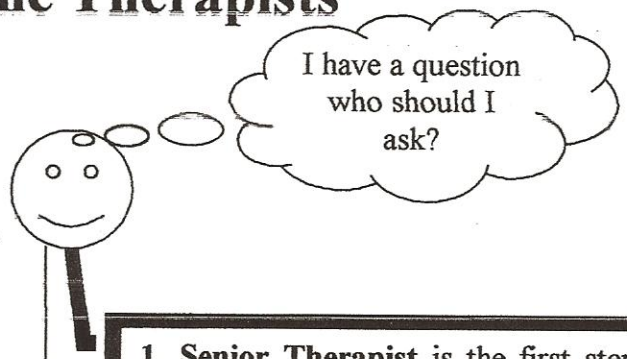
Dr. Colleen Ryan, PhD
Licensed Clinical Psychologist
Autism Spectrum Disorders Specialist
cryan12@msn.com
262.370.7744

Childhood Autism Treatment Team
Childhood Autism Therapies
N1563 County Rd H
Palmyra WI 53156

CHILDHOOD AUTISM TREATMENT TEAM (CHATT)

AUTISM COACH MANUAL

Organizational Chain of Response For Line Therapists



Parents: Approach with child specific questions regarding health, preferences, dislikes, cues/signals, program materials, and session scheduling.

1. Senior Therapist is the first step for all treatment, administrative, training, and policy related questions and concerns. **Hint: When in doubt check it out. It never hurts**

***Parent, family relative, or other service provide has approached you with a concern/question they have regarding the program treatment or personnel*:**

What to do?

1. Redirect them back to the Senior Therapist.

2. Inform the Senior Therapist of this contact and your actions so that they may follow up appropriately.

Why?

You do not have the training or the authority to address topics outside of the treatment intervention procedures. Implementation of one-on-one therapy is the focus of your interactions in the home as a line therapist. Confidentiality and professional boundaries are always a concern in a therapeutic relationship.

2. Line Therapist Team:

When another team member is readily available it is appropriate to problem solve as a group and share ideas. *Interaction with team members should be productive, positive, and objective.*

Team Meetings are opportunities to share information and if extra time is necessary training *overlap* may be available.

Team Talk section of the therapy binder allows for the team members to respond to questions and provide clarification as a group. The senior therapist reviews all entries and will respond.

Overlap with experienced team members is part of the orientation process for hands on training and later for specific training needs determined by the Senior Therapist.

Phone Calls to team members should be limited to schedule coverage due to the confidential nature of the information.

3. **Area Coordinator**: *Training needs or policy concerns where not addressed/answered by my senior therapist and asking my line team or the parents would not be appropriate*: This contact should be productive and objective. The senior therapist will be part of the process in addressing your concern with guidance from the area coordinator.

4. Area Psychologist is available to the treatment team as necessary and will be informed through the area coordinator or senior therapist or parents directly.

Main Office: All contact through your Senior Therapist

Welcome To Our Treatment Team

- **Parents are active participants in the therapy process.**

  Parents are team leaders, they help direct the therapy focus and generalize learning outside of the therapy session. Parents are in direct contact with the senior therapist, trained on program implementation and are available to the line staff for child specific questions. Parents are usually directly involved in managing session schedules.

- **Area Psychologist (Lead Therapist) supervises the over all therapy process.**

  The area psychologist makes a home visit at least once every two months and is available for outside consultation as necessary. The area psychologist supervises area coordinator, senior therapist, assists in development of the program for the child, and monitors the progress of the child and treatment team.

- **Area Coordinator provides direct supervision and supports to senior therapists and treatment teams in a specified service area.**

  Area Coordinator will support the treatment team both directly and indirectly through programming development, training development, resource referrals, consultation with other service providers, skill assessment, review of progress, personnel reviews, and overall coordination of services.

- **Senior Therapist is the direct supervisor of the line therapists.**

  Senior Therapist will actively recruit, train, supervise, evaluate, develop, and lead the line therapist team. The senior therapist has direct contact with the parents for planning and evaluating the program focus and effectiveness. The senior therapist conducts skill assessments and probing, develops program goals and intervention procedures, reviews data patterns, adjusts targets and interventions, consults with other service providers, prepares status reports for state review, and consults with area coordinator and area psychologist on an ongoing basis.

- **Line Therapist provides one-on-one treatment to the child.**

  Line therapists are trained to implement Applied Behavior Analysis interventions as outlined in the child's program binder, collect data and record as specified in each program, attend weekly team meetings, and communicate directly to the senior therapist.

LINE STAFF ORIENTATION

WELCOME TO CHATT

- ☐ Development of Home Based Services and our Agency (brochure)
- ☐ Treatment Team and Roles
- ☐ Chain of Response
- ☐ Complete New Hire Paperwork

Policies & Procedures

- ☐ Review Line Staff Handbook
- ☐ Job Description Detailed
- ☐ Professional Conduct/Ethics
  - o Confidentiality
  - o No Dual Relationships
  - o No Transport of children
  - o Absences and Therapy Hours
  - o Team Meeting Attendance
  - o Appropriate Dress
  - o Treatment Focused Interactions
  - o Giving and receiving gifts limited- check with your senior
  - o Commitment to Learning

Description Autism Spectrum Disorder

- ☐ Autism
- ☐ PDD-NOS
- ☐ High Functioning Autism
- ☐ Asperger's Syndrome
- ☐ Main Domains targeted by treatment
  - o Communication
  - o Behavior
  - o Social
  - o Self-Help
  - o Academic
  - o Motor/Perceptual

Treatment Foundations

Applied Behavior Analysis

- ☐ Functional Behavior Analysis
- ☐ Discrete Trial Teaching
- ☐ Natural Environment Teaching
- ☐ Verbal Behavior Training
- ☐ Direct Instruction
- ☐ Precision Teaching

Commonly integrated into ABA approaches:

- ☐ Greenspan/Floor Time Play Skills
- ☐ Attwood & Carol Gray/ Social
- ☐ Sensory Integration and Vision/Perceptual
- ☐ PECS and Visual Supports
- ☐ Augmentative Devices
- ☐ Expansion of OT, PT, S/L, VT, and other

Treatment Process Overview

- ☐ Assessment/Intake
- ☐ Treatment Goal Determination
- ☐ Treatment Procedure Development
- ☐ Formal Program Development
- ☐ Data Process Determination
- ☐ Team Development
- ☐ Implementation of Programs
- ☐ Ongoing Assessment for Adjustments

Implementation of Programs

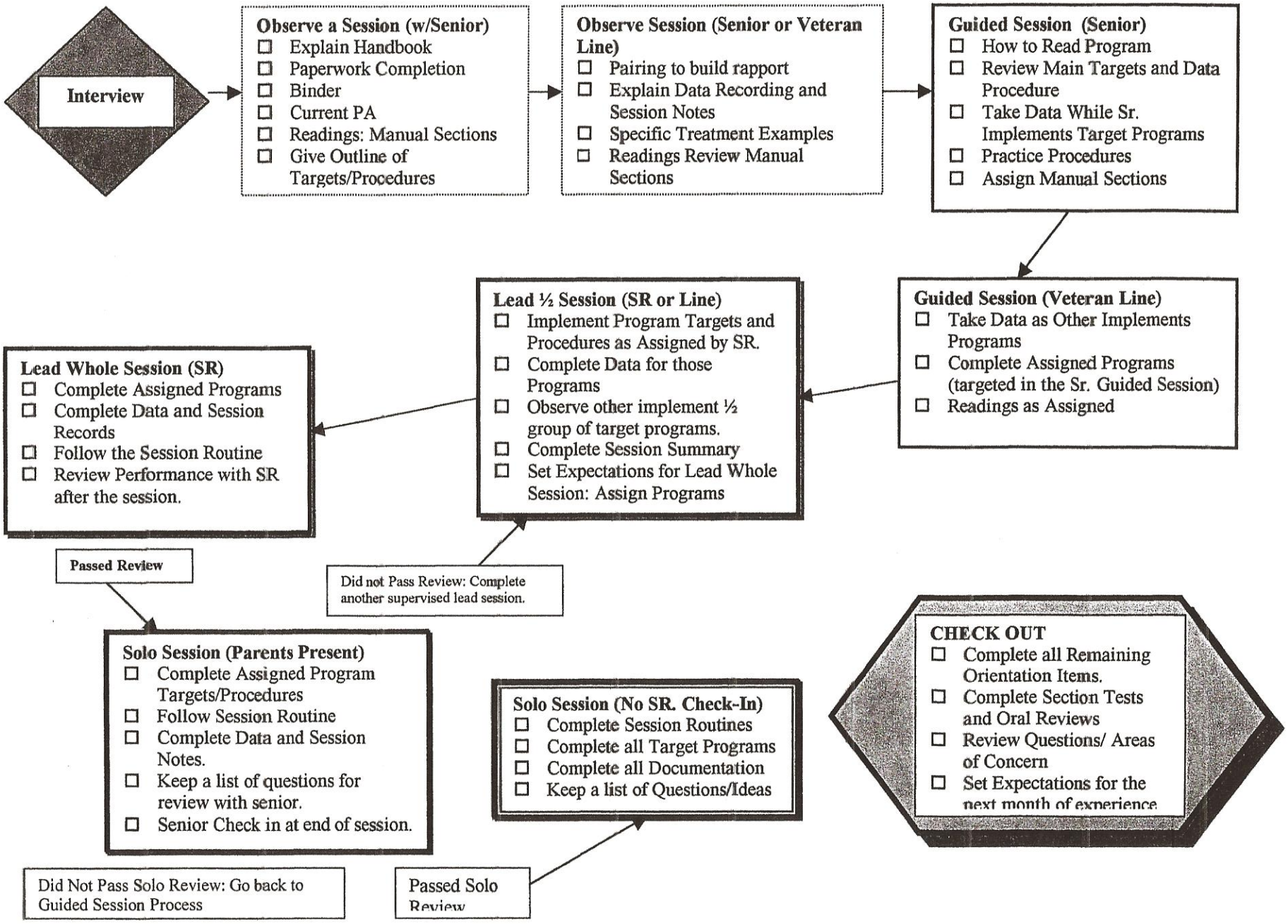
- ☐ Read Program Sheet
- ☐ Use ABA Techniques as Instructed
  - o Pairing (You are a good thing)
  - o EO
  - o Reinforcers
  - o Prompting Hierarchies
  - o Positive Supports
  - o Crisis Management Strategies
- ☐ Fill Out Data Sheets
- ☐ Flow All Programs Throughout the Sessions rather than do each as separate units.
- ☐ Indicators of your effectiveness:
  - o Reduction/Minimal Level 1 or 3 behaviors
  - o Successful Learning Experience (accuracy and rate have increased)
  - o Increased Independence (lower level prompts used)
  - o Comparisons of current session data to past sessions indicate positive development in target behaviors and skills.
  - o Completed all/most target programs within the session period.

Child Specific Information

- ☐ Orientation to the Home Environment
- ☐ Current Status of Functioning (PA summary Monthly Summary, Program Binder)
- ☐ Special medical procedures, diets, or therapies
- ☐ Specific Communication Approaches
- ☐ Support for Stress & Behaviors
- ☐ Session Routine
- ☐ Demonstration of Specific Programs
- ☐ Orientation to daily routines and special community activities
- ☐ Shadow veteran staff

Note: TEAM MEETINGS & WORKSHOPS WILL OFFER CONTINUING EDUCATION. EACH STAFF IS CHALLENGED TO COMMIT TO PERSONAL GROWTH & CONTRIBUTE TO TEAM DEVELOPMENT

LINE STAFF TRAINING GUIDE



Policies & Procedures

- ☐ Line Staff Handbook
- ☐ Parent Handbook
- ☐ Professional Code of Conduct/Ethics Quiz
- ☐ Review Main Issues with Senior

  -Confidentiality
  -No Dual Relationships
  -No Transportation of Clients
  -Absences and Therapy Hours
  -Team Meeting Attendance
  -Appropriate Dress
  -Treatment Focused Interactions
  -Giving and Receiving Gifts limited
  -Mandated Reporter Status
  -Commitment to Learning

MANDATED REPORTING OF CHILD ABUSE AND NEGLECT

WHAT MUST BE REPORTED?

48.02 "Abuse",

- Physical injury inflicted on a child by other than accidental means;
- When used in referring to an **unborn child**, serious physical harm inflicted on the unborn child, and the risk of serious physical harm to the child when born, caused by the habitual lack of self-control of the expectant mother in the use of alcoholic beverages, controlled substances or controlled substance analogs, exhibited to a severe degree.
- Sexual intercourse or sexual contact under *s. 940.225* ($1^{st} - 4^{th}$ degree sexual assault (adult)), *948.02* sexual assault of a child, or *948.025* repeated acts of sexual assault with the same child.
- Sexual exploitation of a child *948.05*; permitting, allowing or encouraging a child to violate prostitution laws *944.30*;causing a child to view or listen to sexual activity *948.055;* exposing genitals or pubic area *948.10.*
- Emotional damage for which the child's parent, guardian or legal custodian has neglected, refused or been unable for reasons other than poverty to obtain the necessary treatment or to take steps to ameliorate symptoms.

48.981 (1)d "Neglect"

Means failure, refusal or inability on the part of a parent, guardian, legal custodian or other person exercising temporary or permanent control over a child, for reasons other than poverty, to provide necessary care, food, clothing medical or dental care, or shelter so as to seriously endanger the physical health of the child.

WHEN MUST MANDATED REPORTERS MAKE A REPORT?

1. They have **reasonable cause to suspect** that a child seen in the course of professional duties has been abused or neglected.
2. **OR** they have reason to believe that a child seen in the course of professional duties has been **threatened** with abuse or neglect and that abuse or neglect of the child will occur. ***(Every instance of child abuse or neglect must be reported.)***

WHO MUST REPORT:

- Acupuncturist
- Administrator
- Alcohol Counselor
- Audiologist
- Child care worker (in a day care or child caring institution)
- Chiropractor
- Coroner
- Counselor
- Day Care Provider
- Dentist
- Dietitian
- Drug Abuse Counselor
- Emergency Medical Technician
- Family Therapist
- Law Enforcement Officer
- Marriage Therapist
- Mediator s.767.11
- Medical Examiner
- Treatment Staff- (person employed or working under contract with a Co. Dept. Human Services)
- Nurse
- Occupational Therapist
- Optometrist
- Other medical professional
- Physical Therapist
- Police
- Professional Counselor
- Physician
- Public Assistance Worker (caseworker who provides financial or employment counseling)
- School teacher
- Social worker
- Speech-Language Pathologist

The above professionals are mandated to report under s. 48.981 (2) WI statutes.

TO WHAT AGENCY MUST MANDATED REPORTERS REPORT? 48.981 (3)

Facts or circumstances contributing to a suspicion of abuse or neglect should be made **immediately** by phone or in person to county department of social or human services, or the sheriff or city, village, or town police department.

WHAT HAPPENS AFTER A REPORT IS MADE? 48.981 (3)

Within 24 hours after receiving a report of abuse or neglect, the county Child Protective Services (CPS) shall initiate an investigation to determine if the child is in need of protection or services. Elements of the investigation may include observation or interview with the child, visiting the child's home, or interviewing the parents/guardian. CPS can meet with the child in any place without the parent/guardian's permission, but may not enter the home without permission. Within 60 days after receiving a report from a reporter, the county department shall inform the reporter what, if any, action was taken.

➲ ***Over for reporting exceptions and frequently asked questions.***

This information sheet was created in 1999 by the Wisconsin Coalition Against Sexual Assault (WCASA). WCASA is a membership organization of sexual assault centers and other organizations and individuals throughout Wisconsin who are working to end sexual violence. For information sheets on additional topics or for membership information, contact WCASA, 600 Williamson St. Suite N2, Madison, WI, 53703. Phone/TTY: 608-257-1516 Fax: 608-257-2150. Information sheets are available in downloadable format from our website www.wcasa.org.

EXCEPTIONS TO REPORTING REQUIREMENTS s. 48.981 (2m)

Purpose of exception: To allow children to obtain confidential **"health care services."**

Health care services *are defined as*:
- Family planning services
- Pregnancy testing
- Obstetrical health care or screening
- Diagnosis/ treatment for sexually transmitted disease

→

To whom does the exception apply?
"Health care providers" *are defined as:*
- Physician
- Physician Assistant
- Registered or licensed nurse

→

What type of abuse does the exception cover?
- Sexual intercourse, or
- Sexual contact
- Involving a child (under 18)

→

When does the exception apply to a mandated reporter?
1. When a "health care provider" provides any "health care services" (see definitions) to a child.
2. When a person obtains information about a child who is receiving or has received "health care services" from a "health care provider."

CIRCUMSTANCES WHEN EXCEPTIONS ARE INAPPLICABLE

*Professionals falling under either exception **must report** if they have reason to suspect **any** of the following:*

1. That the sexual intercourse occurred or is likely to **occur with a caregiver;** or
2. That the child suffered or suffers from a **mental illness or mental deficiency** that rendered or renders the child temporarily or permanently incapable of evaluating the consequences of his/her actions.
3. The child because of **age/ immaturity, was/ is incapable of understanding** the nature or consequences of sexual intercourse or contact.
4. That the child was **unconscious or physically unable to communicate unwillingness** to engage in sexual intercourse or contact.
5. That the other participant in the sexual contact or intercourse was or is **exploiting the child.**
6. Professionals shall report as required if he or she has **reasonable doubt** as to the **voluntariness** of the child's participation in the sexual contact or intercourse.

ANSWERS TO FREQUENTLY ASKED QUESTIONS:

This information does not constitute legal advice.

- Under Wisconsin law, sexual assault service providers (SASPS) are not considered mandated reporters. However, individuals who work or volunteer SASP's may be mandated reporters due to their profession, such as licensed social workers, etc. Many agencies and their Boards of Directors formulate policies that consider all staff and volunteers of the agency to be mandated reporters.
- Additionally, certain grant monies may stipulate that an agency follow mandated reporting requirements.
- It is good practice for agencies to develop a policy on mandated reporting. In some programs, employees are told to report to a particular staff person. This staff person would make the report, as required by law.
- In other programs, workers are told to inform a client who gives information about child abuse or neglect that the program will notify social services and it would be best if the client reported the incident(s) before the program does so. The program gives the client a very brief length of time in which to make the report and then contacts social services with the information.
- Mandated reporters are required to report "child abuse" or "neglect." The definition of "child abuse" does not include the sexual assault law referring only to 16 and 17 year olds, s. 948.09 (Whoever has sexual intercourse with a child who is not the defendant's

To better understand mandated reporting, review sexual assault laws, child sexual assault laws and WCASA information sheet on teens.

"voluntary"sexual activity of a 16 or 17 year old, though still illegal, need not be reported as child abuse UNLESS the reporter suspects any of the elements considered under the above listing (CIRCUMSTANCES WHEN EXCEPTIONS ARE INAPPLICABLE) or suspect any elements under s. 940.225 such as use of force etc.

FREQUENTLY ASKED QUESTIONS ABOUT AUTISM SPECTRUM DISORDERS

What is Autism?
Autism is a life long developmental disability typically affecting the processing, integrating, and organizing of information that significantly impacts communication, social interaction, functional skills, and educational performance. Individuals with autism require direct teaching to learn patterns of speech and communication, and appropriate ways to relate to people, objects, and events. It is also important to emphasize the fact that autism is a neurological disorder. Studies have found abnormalities in the central nervous systems of persons with autism.

Are there varying degrees of Autism?
Yes, people may have mild, moderate or severe autism. These designations refer to the degree, (duration, frequency, or intensity) of behaviors when the individual demonstrates autistic characteristics. Differences among individuals with autism are pronounced. Although autism is defined by a core set of behaviors, children and adults exhibit many combinations of behaviors, in varying degrees of severity.

Autism is often referred to as a "spectrum disorder," meaning that the symptoms and characteristics of autism can present themselves in a variety of combinations, ranging from extremely mild to quite severe. Research has suggested that the further along the autistic spectrum, from severe to mild, the more varied the presentation.

What are the characteristics of Autism? Symptoms of autism usually appear during the first three years of childhood and continue throughout life. Although there is no cure, appropriate management may foster relatively normal development and reduce undesirable behaviors. People with autism have a normal life expectancy. The degree and severity of characteristic differs from person to person, but usually includes the following:
Severe delays in language development: Language is slow to develop, if it develops at all. If it does develop, it usually includes peculiar speech patterns or the use of words without attachment to their typical meaning. Those who are able to use language effectively may still use unusual metaphors or speak in a formal and monotone voice.
Severe delays in understanding social relationships: Tend to avoid eye contact, resists being picked up, and seems to "tune out" the world around him/her. This results in a lack of cooperative pay with peers, an impaired ability to develop friendships, and an inability to understand other people's feelings or perspectives.
Inconsistent patterns of sensory responses: The child with autism may appear to be deaf and fail to respond to words or other sounds. At other times, the same child may be extremely distressed by everyday noises such as the vacuum cleaner or a phone ringing. The child also may show apparent insensitivity to pain and a lack of responsiveness to cold or heat, or may over-react to any of these.
Uneven patterns of intellectual functioning: The individual may have peak skills- scattered things done well in relation to overall functioning- such as drawing, music, computations in math, or memorization of facts with no regard to importance or lack of it. On the other hand, the majority of children with autism have varying degrees of mental retardation, with only 20 percent having average or above average intelligence. This combination of intellectual variations makes autism especially perplexing.
Marked restriction of activity and interests: A person with autism may perform repetitive body movements, such as hand flicking, twisting, spinning, jumping, or rocking. This individual may also display repetition by following the same route, the same order of task completion, or the same activity schedule each day, etc. If change occurs in these routines, the preoccupied child or adult usually becomes very distressed

How is the diagnosis of autism made? Are there special tests my doctor can do to determine whether a child is autistic?
The diagnosis is made by a professional experienced in the evaluation of children with developmental disorders. A qualified professional may be a pediatrician, pediatric neurologist, child psychiatrist, or psychologist. The diagnosis is based on a history of the child's development provided by those who know the child well, as well as clinical interview/observation of the child.

What causes Autism?
Given the limits of our neurological understanding of autism, it is impossible to point to a single cause of autism. It appears that there are many causes, and research continues. Recent research in neuroanatomy has indicated abnormalities in the brains of individuals with autism. It is still unknown why these areas of the brain develop differently in individuals with autism.

Studies have shown a genetic correlation to autism in some individuals. Other possible causal factors such as birth trauma, vaccine reactions and prenatal viruses have also been associated with autism.

In short, anything that causes the central nervous system to develop abnormally may cause autism. Because of a lack of specific information about what causes this syndrome, some people may be distracted from seeking effective interventions. Thirty years ago the term "refrigerator mothers", was used to describe what was supposed to be a typically cold and distant mother of a child with autism. It is now clear that there is no psychological or psychogenic cause for autism.

How common is Autism?
Autism affects an estimated two to 10 of every 10,000 people, depending on the diagnostic criteria used. Most estimates that include people with similar disorders are two to three times greater. Autism strikes males about four times as often as females, and has been found throughout the world in people of all racial and social backgrounds.

What is the difference between Autism , PDD, and PDD-NOS?
Pervasive Developmental Disorder (PDD) is a category designated by the American Psychiatric Association to indicate children with delay or deviance in their social /language/motor and /or cognitive development. A child may have delays in social development and delays in one or more of the other categories. The profiles of children with a PDD can vary tremendously. PDD is not one disorder but a category that encompasses a wide range of delays of different magnitude in different domains. Autism is the most severe of the pervasive developmental disorders. Autism indicates a primary disturbance in the individual's ability to relate to others. Language delay and cognitive delays are also common.

PDD-NOS represents Pervasive Developmental Disorder-Not Otherwise Specified. This is a diagnosis given to a child who exhibits impairment in the development of reciprocal social interaction, verbal and non-verbal communication, or when stereotyped behavior or activities are present. However, the child does not meet the criteria for any specific pervasive developmental disorder.

What disorders are included under the PDD category?
Pervasive Developmental Disorders include the following DSM-IV (APA, 1994) subheadings: Autistic disorder (Classical or Kanner's autism), Rett's syndrome, Childhood disintegrative disorder (CDD), Asperger's syndrome (AS), and Pervasive developmental disorder, not otherwise specified (PDD,NOS).

Does Autism occur in conjunction with other disabilities?
Autism can occur by itself or in association with other developmental disorders such as mental retardation, learning disabilities, epilepsy, etc....

What is the difference between Autism and Mental Retardation?
Most people with mental retardation show relatively even skill development, while individuals with autism typically show uneven skill development with deficits in certain areas-most frequently in their ability to communicate and relate to others- and distinct skills in other areas.

It is important to distinguish autism from mental retardation or other disorders since diagnostic confusion may result in referral to inappropriate and ineffective treatment techniques.

Are there other conditions that can mimic autism?
There are several other conditions that can look similar to autism. Some of these fall within the PDD spectrum. Rett's Disorder, Heller's syndrome- also know as Childhood Disintegrative Disorder (CDD), Children who are deaf, Children with Developmental Language Disorder or Semantic-Pragmatic Disorder, and Landau-Kleffner Syndrome (LKS), which is also called Acquired Aphasia with Epilepsy are a few disorders that can look similar to autism.

What is the most common problem in autism?
Individuals with autism have extreme difficulty in learning language and social skills and in relating to people.

How does autism effect behavior?
In addition to sever language and socialization problems, people with autism often experience hyperactivity or unusual passivity in relating to parents, family members, and other people.

Many children with autism seem to be very stubborn. While that maybe true it is also true that this is a far too simplistic rationale for the behaviors.

Keep in mind the role that neurological impairments play in the behaviors of children with autism. What may seem like an example of stubbornness may result from not having understanding or empathy for others. This often results in self-centeredness.

Confusion is common in the lives of children with autism. When steps are taken to help them understand their environment and what is expected of them, it is possible to reduce or replace behaviors that previously seemed to be examples of stubbornness.

Why do children with autism often display these behaviors; compulsiveness, perfectionism, odd movements and a need for organization?
Perfectionism, odd movements and a need for organization may be viewed as compensating behaviors that help individuals with autism cope with their various neurological impairments. These compensating behaviors often provide individuals with some much needed stability in a world that may seem very confusing.

What is different about this child's sensory systems?
Children with autism may be hyposensitive or hypersensitive in their responses to various sensory input. Being hyposensitive may include a high degree of tolerance to pain. This circumstance can be dangerous and should always be considered when children with autism are working around hot surfaces or objects.

How can autism be treated?
There is no cure for autism at present. Therapies, or interventions, are designed to remedy specific symptoms in each individual. The best-studied therapies include educational/behavioral and medical interventions. Although these interventions do not cure autism, they often bring about substantial improvement.

Educational/behavioral interventions: These strategies emphasize highly structured and often intensive skill-oriented training that is tailored to the individual child. Therapists work with children to help them develop social and language skills. Because children learn most effectively and rapidly when very young, this type of therapy should begin as early as possible. Recent evidence suggests that early intervention has a good chance of favorably influencing brain development. Medication: Doctors may prescribe a variety of drugs to reduce self-injurious behavior or other troublesome symptoms of autism, as well as associated conditions such as epilepsy and attention disorders. Most of these drugs affect levels of serotonin or other signaling chemicals in the brain.

Many other interventions are available, but few, if any, scientific studies support their use. These therapies remain controversial and may or may not reduce a specific person's symptoms. Parents should use caution before subscribing to any particular treatment. Counseling for the families of people with autism also may assist them in coping with the disorder.

What is an ABA program?
There are three components of ABA that all have to work together: families and teachers, therapists, and practice. And they have to work together for quite a while - every child is different but we are talking years, not weeks or months.

The people are therapists, family and other caregivers. The "programming" as this teaching is often called, is the most distinguishing feature of an ABA program. Bits and pieces of the practice show up in many other "methods" or therapeutic approaches. Many people believe that it is this tremendous discipline and attention to detail that makes it possible for some children to become able to be integrated with their peers into a normal classroom setting.

Teaching is all about learning an appropriate behavior in a situation. The lessons are individualized to the child to learn language, play, and social skills; A proper program is custom made to your child's needs, abilities and interests.

Finally, it is how skills are taught, that at first seems the most unusual feature of ABA. A lot happens in these consistent teaching or "programming" sessions, but there are things that parents and others can do at other times and in other settings to help the child learn. Again, a Senior Therapist will help you learn how to reinforce appropriate behaviors, to help the child, as he/she learns new skills, to learn appropriate behaviors.

Why can't the child with autism learn naturally, instead of behaviorally? ABA looks so unnatural.
Child development involves an astounding amount of learning in a remarkably short time. Children with autism are typically far behind their peers in many, if not most of the "normal" milestones, even as young as age 2. They will not suddenly learn "naturally" if they are not prepared with the basic skills they need to understand and cope with what is happening in the world around them.

Doesn't ABA lead to "robot-like" behavior?
Any behavior, as it is learned, is awkward and may produce an artificial appearance. As the behavior becomes natural and comfortable for the child that will gradually disappear. Think about learning how to drive - at first it was very stilted and "robot-like" but as the comfort level increased, the awkwardness decreased.

What is Dysfunction in Sensory Integration?
Dysfunction in Sensory Integration (DSI) is a problem in processing sensations, which causes difficulties in daily life. DSI is a complex neurological disorder, manifested by difficulty detecting, modulating, discriminating or integrating sensation adaptively. DSI causes children to process sensation from the environment or from their bodies in an inaccurate way, resulting in "sensory seeking" or "sensory avoiding" patterns or "dyspraxia," a motor planning problem.

DSI and Sensory Seeking: These children have nervous systems that do not always process that sensory input is "coming in" to the brain. They are under-responsive to sensation. As a result, they seek out more intense or longer duration sensory experiences. Some behaviors that can be observed are:

- ☐ Hyper-activity as they seek more and more movement input
- ☐ Unawareness of touch or pain, or touching others too often or too hard (may seem aggressive)
- ☐ Engaging in unsafe behaviors, such as climbing too high
- ☐ Enjoying sounds that are too loud, such as TV or radio volume

DSI and Sensory Avoidance: These children have nervous systems that feel sensation too easily or too much. They are overly responsive to sensation. As a result, they may have "fight or flight" responses to sensation, a condition called "sensory defensiveness." Some behaviors that can be observed are:

- ☐ Responding to being touched with aggression or withdrawal
- ☐ Afraid of, or becomes sick with movement and heights
- ☐ Very cautious and unwilling to take risks or try new things
- ☐ Uncomfortable in loud or busy environments such as sports events, malls
- ☐ Very picky eater and/or overly sensitive to food smells

DSI and Dyspraxia: These children are clumsy and awkward. They have particular problems with new motor skills and activities. Some behaviors that can be observed are:

- ☐ Very poor fine motor skills such as handwriting
- ☐ Very poor gross motor skills such as kicking, catching, throwing balls
- ☐ Difficulty imitating movements such as "Simon Says"
- ☐ Trouble with balance, sequences of movements and bilateral coordination

The Tool Box

Applied Behavior Analysis

A⇨B ⇨C Model

A = Antecedent Behavioral or any environmental events that occur just prior to behavior.

External (outside) could include setting, events, tasks, activities, people, sensory inputs etc.
Internal (inside) could include moods, medical conditions, disabilities, psychiatric conditions etc.

Skill Deficits vs. Performance Deficits
Skill deficit student lacks the necessary information or component skills =
Teach the skill!

Skill performance deficit has performed skill in some settings, but does not generalize =
Provide opportunities for student to perform skill and reinforce the target behavior while not reinforcing the maladaptive behaviors.

B = Behavior Any overt or covert activity of a person (response). Defined in observable, factual terms.

Target Behavior is defined as behavior required at the successful termination of the intervention. Note: Target Behavior is not the same as Behavior Intervention Target (BIT).
Maladaptive Behavior (Behavior Intervention Target) is defined as any behavior student engages in which is considered harmful to the student's or another person's social, emotional, physical, or academic well being.

C = Consequences- Non ambiguous reaction to whatever behavior is exhibited by the leamer.

- What happens after behavior that serves to strengthen or weaken the behavior?
- What does student do, what do peers do, what does instructor do, what does parent do?
- What change occurs in the interaction, activity, environment, sensory input, physical state, and emotional state etc?
- What purpose did the behavior serve (communication, need gratification, attention, personal space, sensory input, avoid task, interrupt interaction etc.)?

Applied Behavioral Analysis (ABA)

A science that seeks to use empirically validated behavior change procedures for assisting individuals in developing skills with social value.

Constellation of Procedures
Typically includes the use of discrete trial instruction but is not limited to that method of instruction.

ABA instruction consists of highly *structured* instruction and *reinforcement* provided at a high intensity using precise teaching techniques: Intensive Behavioral Intervention.

Properly designed and executed ABA programs contain many if not all of the components of effective treatment approaches found to be most successful in treating children with autism:

- Individualized Instruction tailor made to address the needs of a specific child.
- Behaviorally based methodology
- Low student teacher ratio
- Early treatment
- Family Involvement

Purpose of ABA is to teach children how to learn. Emphasis is placed on acquiring new behaviors because when children have a repertoire of constructive behaviors, problem behaviors often occur less frequently.

- *Behavioral methods* enhance learning process by teaching new skills and replacing challenging behaviors with more adaptive behaviors. Positive Reinforcement of target behaviors serves as primary technique.

- *Progress is closely monitored* by detailed data collection to support target behavior development through stages: skill acquisition, proficiency, maintenance, and generalization.

- *Learning is made fun* for the child and addresses the need for *age appropriate* play skills and *social* behavior. Through support of peer interactions and incidental teaching, skills can be generalized to progressively less structured settings and more naturalistic situations supporting transfer of responsibility from the instructor to the child (intrinsic motivation and reinforcement for target behaviors).

What is DTT-NET all about?

The DTT-NET teaching approach is based on B.F. Skinner's Functional Analysis of Verbal Behavior (I957), and more recently, Sundberg and Partington's Teaching Language to Children with Autism or Other Developmental Disabilities (1998). This approach has recently been popularized through the workshops and conferences of Dr. Vincent Carbone and Dr. Patrick McGreevy.

A Brief Introduction to ABA, DTT, NET, DTT-NET, and Lovaas

What is ABA?

ABA stands for Applied Behavioral Analysis. It is also known as behavior modification, and it is the branch of psychology that studies behavior. Applied Behavioral Analysis views autism as a syndrome of behavioral deficits and excesses, which can be changed with careful programming. ABA treatment focuses on breaking down behaviors into small steps, and then teaching each step (**initially** in an intensive, one-to-one situation) in succession, providing guidance in the form of prompts, and providing positive reinforcement for correct responding.

What is DTT?

DTT stands for Discrete Trial Training. A discrete trial consists of an SD (or an instruction from the teacher), a response, and a consequence. Discrete Trial Training is teaching which uses many discrete trials in teaching situations.

What is NET?

NET stands for Natural Environment Training. This type of training focuses on the child's immediate interests and activities as a guide for instruction. It is conducted in the child's typical daily environment rather than in a formal teaching arrangements. Stimulus and response variation is stressed, and consequences are natural. Many different teaching techniques, including DTT, can be used in the NET environment.

What is DTT-NET?

DTT-NET stands for Discrete Trial Training (or Teaching) - Natural Environment Training (or Teaching). This type of teaching is based on the principles of Applied Behavioral Analysis. DTT-NET. is an acronym used to discribe a listgroup that focus on teaching language to children with autism. The Language Instruction is based on B.F. Skinner's "Analysis of Verbal Behavior" (1957) and more recently, Sundberg and Partington's "Teaching Language to Children with Autism or Other Developmental Disabilities" (I 998). This component of ABA has recently been popularized through the seminars, workshops, and conferences of Dr. Vincent Carbone and Dr. Patrick McGreevy. This is the focus of this list. It may also be referred to as the S/P method, or the Carbone method.

What is "Lovaas"?

"Lovaas" refers to Dr. Ivar Lovaas of UCLA. Dr. Lovaas was the first to develop a program using ABA principles for children with autism. In his landmark study, 9 of 19 children were found to have "recovered," that is, became indistinguishable from their peers, after being treated using Dr. Lovaas' program 40 hours per week, for two years or more. Many people use the terms "ABA program" and 'Lovaas program" and "Discrete Trial Training" interchangeably, however, a "Lovaas program" is a type of ABA programming for young autistic children which uses a large number of discrete training trials in the work setting.

How does DTT-NET differ from "Lovaas"

DTT-NET and "Lovaas" are both intensive treatment programs for developmentally disabled children. Both teaching programs advocate for a large number of hours of one-one-one teaching for young children. Both programs utilize the principles of Applied Behavioral Analysis, and have Discrete Trial Training as an important teaching tool. However, these programs differ in several important ways:

DTT-NET	Lovaas Program
• Views language as defined by Skinner's behavioral classification, divides spoken language into receptive, echoic, tact, mand, RFFC, and intraverbal.	• Views spoken language primarily as receptive and expressive.
• Focuses on early mand training.	• Focuses on early receptive language and verbal imitation.
• Presents learning opportunities both in formal and informal teaching settings and in the child's natural environment.	• Presents learning opportunities mainly in formal teaching settings.
• Stimulus items chosen by based on the child's interests.	• Teacher chooses the stimulus items.
• Delivers natural reinforcers paired with social reinforcement (child says "ball" and gets a ball to play with).	• Delivers other reinforcment with social reinforcment (child says "ball" and get an M&M).
• Utilizes errorless teaching approach.	• Utilizes a NO-NO-Prompt sequence for incorrect responses and mastered items.
• Varies stimulus and response every few trials from the beginning of the treatment program.	• Uses mass trials to teach new items, and not vary stimiulus and responses until much later in the treatment program.
• Teaches to fluency, that is, responses must be quick, strong, and loud, over 3 consequtive, independent probes.	• Teaches to a mastery criterion typically 80-90% over three consecutive teaching sessions.
• Probes daily for data collection.	• Takes data on every discrete trial performed.

Childhood Autism Treatment Team / Childhood Autism Therapies - Timesheet 2012

Child Name:

Therapy Month:

Therapist Name (signature)	Work Date	Time In	Time Out	Hours Worked (in-home)	Travel Hours	Hours outside home	Staffing Hours	Month Total

Employee Signature	Hours for Month

Senior Staff: Collect, Validate Data, & Submit monthly by 5th of next month
Fax: 262-495-8689 or
Scan/Photo+Email to: cryan12@msn.com
or Mail to: Colleen Ryan,
N1563 County Rd H, Palmyra WI 53156
(Contact Mike R. 262-370-5527 with any issues)

Family/Guardian Signature:

Date: