Handout

Background:

Autism Spectrum Disorder (ASD) is one of the fastest growing developmental disabilities in the country (Baio et al., 2014). Finding qualified practitioners in various disciplines to serve this growing client base has proved to be a challenge (e.g., Ingersoll, Wainer, Berger, Pickard, & Bonter, 2016; Leaf et al., 2017; Terry, 2009). Both speech language pathologists (SLPs) and Board Certified Behavior Analysts (BCBAs) work closely with individuals with ASD. While speech pathology has been an established profession for almost 100 years (ASHAa, 2019), Board Certified Behavior Analysts are relatively new professionals, (e.g., the Behavior Analyst Certification Board was established in 1998) with a burgeoning workforce (BACBa, 2019; See Table 1).

Differences in theoretical perspectives and intervention strategies are evident and provide an insight into differing intervention models. The biggest difference appears to begin with the foundational underpinnings that guide each discipline. BCBAs are guided by behavior analytic principles and theories while SLPs are guided more by developmental theories and foundations (Cardon, 2017). Behavior analysts overwhelmingly subscribe to Skinner’s Theory of language acquisition (91%), while speech pathologists are spread out among several different theories of language acquisition (e.g., Cognitive/Semantic = 41%; Constructivist = 10%; Psycholinguistic = 13%; Pragmatic = 13%; Cardon, 2017). While speech pathologists take into account developmental norms and relationship-based interactions in language acquisition, behavior analysts look at language as a contingency mediated behavior. Both disciplines are required to follow evidence based practices and both support individuals with ASD. How they go about that task differs based on the aforementioned theoretical differences.

Different types of collaborative interventions:

Steps to **Functional Communication Training**

* Teachers/practitioners identify:
  + An inappropriate behavior (e.g., hitting, grunting, falling to the floor) that is serving some type of communicative function and that is being reinforced (perhaps unknowingly) so that it occurs on a regular basis; or
  + A subtle communicative attempt that can be replaced with a more socially accepted form of communication.
* Operationally define the target behavior
  + Observable & Measurable
* Take Data
  + Track the target behavior
    - When does it occur?
    - How long does it last?
    - How long between target behaviors?
    - How intense is the target behavior?
* Look for a Pattern
  + What happened right before the behavior occurred?
    - Antecedent
  + How did you respond?
    - Consequence
* Choose a replacement behavior that is **efficient** & **effective**
  + The **replacement behavior** should be simple enough to:
    - Be taught in a short amount of time; and
    - Allow the learner to quickly acquire the behavior and gain access to the reinforcement.
* Teachers/practitioners identify a replacement behavior that is acceptable and appropriate for both the environment and the learner.
* Choose a replacement behavior that is recognized by multiple communicative partners.
* TEACH the replacement behavior
* Track the data!!!
* Create environments for success
* Prompt for Success
* Reinforcement!

Steps to **Pivotal Response Treatment**:

* Natural Environment & Caregivers - The environment should be arranged to increase a child’s opportunities for communication.
* Child choice & Motivation - A child must be motivated enough to continue trying to get the object or activity.
* Instruction & Response - Instruction should be delivered clearly while the child is attending to the task.
* The child’s response should be clear, directed and appropriate to the task.
* Maintenance Tasks - Because talking is hard, be sure to intersperse new tasks with something the child is really good at and already knows how to do.
* Contingency - If the child produces a vocalization, then the child gets the object or activity.
* Be sure to be consistent once you have set up the opportunity.
* If you set it up, then you must follow through or the child will learn that there are exceptions to the rule!
* Reinforce attempts - Reasonable attempts should IMMEDIATLEY be reinforced.
* Direct & natural reinforcers - Reinforcement should be directly and functionally related.

Interprofessional Collaboration:

The goal of interprofessional education is to support collaboration between disciplines to improve service delivery and outcomes for clients (Hammick, Freeth, Koppel, Reeves, & Barr, 2007). A barrier to interprofessional collaboration has been described as the *collaboration blind spot* (Kwan, 2019). A collaboration blind spot occurs when groups feel threatened and forced into a collaboration that involves sharing information, sacrificing autonomy, and even what may feel like training someone else to do your job. When groups feel threatened, they tend to get defensive and attempt to guard their territory. This defensive posture is evident in the aforementioned social media concerns. To address collaboration blind spots, Kwan recommends a) reinforcing the identity and legitimacy of each individual group, b) recognize threats based on control and identify areas of strength supported by each group (See Table), and c) recognize the existence of collaboration blind spots and bias.

It is imperative that SLPs and BAs learn how to better collaborate to support clients.

Koenig and Gersener (2006) provided the following tips for interprofessional collaboration:

1. Share treatment efficacy data

2. Share innovative teaching procedures

3. Share basic information about his or her discipline

4. Share experiences of successful collaboration

5. Share key articles in professional journals

6. Share concerns about particular shared practice events

7. Share lunch (p. 6)

Research and reviews, such as the National Standards Project and the National Center for Professional Development, have provided evidence to guide the intervention strategies utilized by both disciplines (e.g., Howard, Ladew, & Pollack, 2015; Wong et al., 2015;  ASHA Evidence Maps: Autism 2019). Strengths and areas for interprofessional collaboration for SLPs and BCBAs are described in the Table.

*Strengths & Opportunities for Collaboration of SLPs & BCBAs*

|  |  |
| --- | --- |
| Strengths | |
| SLPs | BCBAs |
| Comprehensive Diagnostic Training | Data Collection Strategies |
| Broad Understanding of Communication | Behavior Modification |
| Developmental Norms | Behavior Assessments |
| Articulation/Phonology Experts | Understanding of Reinforcement |
| Swallowing Experts | Single Subject Methodology |
| Language Forms | Language Functions |
| AAC Assessment |  |
| Opportunities for Collaboration | |
| SLPs | BCBAs |
| Behavior Modification | Developmental Norms |
| Behavior Assessments | Articulation/Phonological Awareness |
| Single Subject Methodology | Understanding of Communication Assessments |
| Data Collection Strategies | Apraxia of Speech |
| Feeding | Feeding |
| Preference Assessments | Language Sampling |
| Augmentative Communication | Augmentative Communication |