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RESEARCH: Behavior Safety and Clinical Practice in Intellectual and Developmental Disabilities

This book series brings leading researchers and clinicians together to collaborate on books that present current research-based evidence for specific treatments across a broad range of subject areas. These books not only identify evidence-based practices, but also practice-based evidence. Furthermore, each book identifies the gaps in knowledge for future research.

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Editors



James K. Luiselli, ED.D., ABPP, BCBA-D



Frank L. Bird, M.Ed., LABA, BCBA, CDE®



Helena Maguire, M.S., LABA, BCBA, CDE®



Rita M. Gardner, M.P.H., LABA, BCBA, CDE®



Behavior Safety and Clinical Practice in Intellectual and Developmental Disabilities

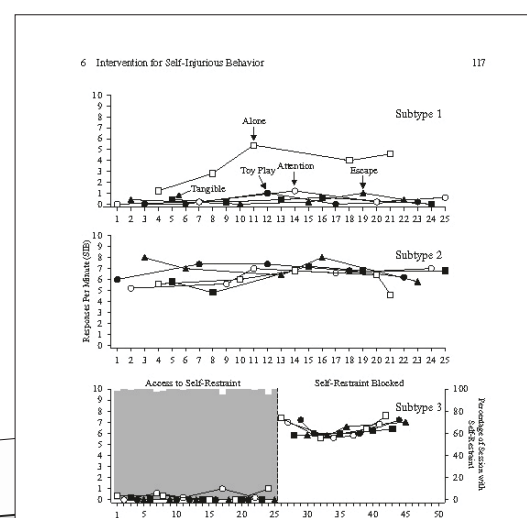


Fig. 6.2 ASIB subtype graphs

minimized within the alone/ignore condition, conditions that test for social functions can be conducted with the sensory extinction or noncontingent reinforcement in place. If SIB is elevated in these social test conditions compared to the alone condition with sensory extinction or noncontingent reinforcement in place, it can be concluded that SIB also serves a social function. In addition, the rates of SIB between reinforcement intervals that exceed those observed in the alone/ignore condition can serve as another indicator that SIB is multiply maintained (Cebalzar et al., 2017). When evaluating multiply maintained SIB, it is essential to consider the safety implications of any equipment used to implement sensory extinction as well as the items used for noncontingent reinforcement, especially if and when they might be used to engage in SIB. In this situation, hard items should be avoided for item-to-head SIB.

Item	Class	Category
Body Parts: Includes the body parts contained in the implementation of physical restraint	1. Head	1. Head
Staff: Includes the number of staff implementing physical restraint	2. Staff	2. Staff
Restraints: Includes the degree of restraint as demonstrated during implementation of physical restraint	3. Restraints	3. Restraints
Items: Includes the potential for injury to children during implementation of physical restraint	4. Items	4. Items
Time: Includes the risk score of body parts/restraint in place	5. Time	5. Time
Equipment: Includes the equipment used during physical restraint	6. Equipment	6. Equipment
1. Mild restraint	1. Mild restraint	1. Mild restraint
2. Moderate restraint	2. Moderate restraint	2. Moderate restraint
3. Severe restraint	3. Severe restraint	3. Severe restraint
4. Extreme restraint	4. Extreme restraint	4. Extreme restraint

Fig. 8.2 Severity and risk assessment

As a consideration when implementing PR, one provider protective equipment may be recommended for clinical safety (Risher et al., 2013) although only a few studies have been conducted. Urban et al. (2011) evaluated the effects of teachers wearing shoulder-to-vent length pads under their clothes and baseball caps to protect themselves from hitting and hair pulling respectively in an 11-year-old boy with autism. Compared to a baseline (no equipment) phase, the pads and baseball caps reduced the frequency and severity of arm and scalp injuries. Latt et al. (2012) conducted an 11-year-old boy with autism who injured teachers by scratching the palms and back of their heads severe enough to cause abrasions, cuts, and bleeding. In the baseline, the teachers interacted with the boy without protective equipment. The

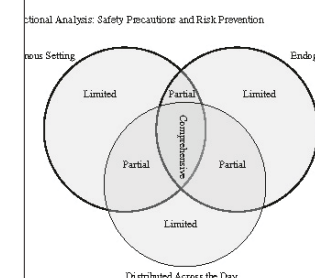


Fig. 8.1 Average number of physical restraint and average

Figure 8.1 (top panel) shows that during the baseline (17 days) on average 11.0 minutes per day (range = 30 seconds–22 minutes) medication was administered during the intervention phase. Medication was administered during only duration of 0.10 minutes per day. Physical restraint up periods had been eliminated. The bottom panel shows Dwyer demonstrated during baseline (17 days) 69.1% (range = 25–100%), 65.0% (range = 0–100%), and 90.0% (range = 0–100%) during baseline and follow-up phases. Summarizing the cases, frequent and long course of systematic behavioral intervention

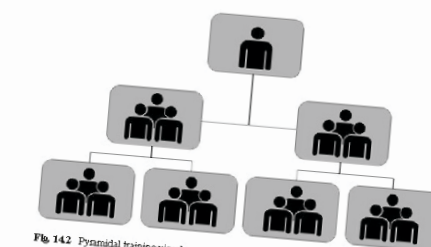


Fig. 14.2 Pyramid training diagram

peers who then train other care providers (see Fig. 14.2; Parsons et al., 2013; Pence et al., 2014). This training approach was previously referred to as peer training (Pence & Stumm, 2009; Van den Pol et al., 1993). With pyramid training, expert trainers are required to train both the protocol of interest and the procedures to train job training. First, the expert trainer must ensure that the peer trainer can accurately administer medication to the person served. If the peer trainer can accurately administer medication to the person served, the expert trainer should train the peer trainer how to use the protocol. Once the peer trainer has been trained, the expert trainer should use BST to train other care providers how to administer medication. A competency-based training approach should be used to train the peer trainer how to effectively use the protocol and how to train others. If they are ready to train the care provider to administer medication.

Pyramid training is beneficial to use in practice as more trainers are available, making it more cost and resource efficient for the organization. It also presents additional training opportunities for care providers to expand on their skills and obtain more responsibility. Additionally, research has shown that care providers demonstrated a higher percentage of protocol implementation when they were trained using pyramid training rather than a consultant-led training (Hobson et al., 2012). Pyramid training has been used to teach care providers how to implement BST (Blackman et al., 2022a; Conklin & Wallace, 2018; Eddy et al., 2013, 2021; Parsons et al., 2013); functional analysis (Pence et al., 2014); responding to problematic behaviors (Conklin & Wallace, 2018; Shore et al., 1995); self-sleeping procedures

Safety concerns are a priority among persons with intellectual and developmental disabilities (IDD) who may be susceptible to accidents and injuries, lack self-preservation skills that avoid hazardous exposure, and demonstrate harmful behavior such as self-abuse, aggression, and property destruction. Care providers also must be aware of personal safety when intervening physically with service recipients in crisis situations and on the basis of treatment plans. Within program settings, safety precautions extend to environmental care, staff training, and mitigation of workplace risk factors.

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