Risk Categorization and Clinical Decision-Making Tool to Ensure Alignment with Trauma-Informed Care

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Introduction

- Identifying needs for complex cases and increasing support within a large organization requires nuanced tools (Horner & Kittelman, 2021) as well as additional supports and system changes (McGee & Crowley-Broch, 2019).
- A questionnaire-based behavior categorization tool was designed to categorize clients' level of high-intensity/ dangerous behaviors based on risk, magnitude of behavior, and ability to predict establishing operations (EO; triggers).
- Decision-making models have been long used in the field of Behavior Analysis and exist for selecting function-based treatments for interfering behaviors maintained by attention (Grow et al., 2009) and escape (Geiger et al., 2010), however, both recommend the use of extinction-based procedures.
- The three-tiered decision-making model provided to teams was made up of actionable steps to ensure competence and support providing trauma-informed care and client progress without the use of extinction or restrictive practices.
- Additional interventions, oversight, and recommendations were made for each tier based on the client's categorized risk.

- **Purpose**: Evaluate if a risk-categorization questionnaire would be a useful tool to identify complex cases and/or Supervising Clinicians that require additional support to implement trauma-informed care that would improve client outcomes (decrease high intensity or dangerous behaviors).

Methodology

Participants

- 191 BCBAs completed the risk categorization questionnaire for a variety of clients on their caseload.

Setting

- BCBAs across three regions (MA, MI, and AZ) completed the questionnaire. ABA services were provided to clients across environments in these regions (home, community, and/or center).

Risk Categorization Questionnaire

- A closed-ended dynamic questionnaire was utilized using Google forms. Supervising Clinicians (SC) were asked to complete the questionnaire by their direct supervisor (Director of Clinical Services) for clients on their caseload.
- The questionnaire first required the SC to identify if the client engages in dangerous behaviors and the topography of behavior that was associated with the highest level of risk
- Next, questions were answered that assigned the client to a risk level (*See Figure 1*). Once a risk level (2,3,4) was determined, risk-level specific questions (*See Figure 2*) were answered to categorize risk further (e.g., A, B, C, D).

Risk Categorization Feedback

- Once a response was submitted, automated emails were sent to the client's SC and DCS with a summary of responses, assigned category and link to the action tool.
- Area Directors were provided with access to client categorizations that could be sorted by DCS or risk level.

Social Validity Questionnaire

- A three question, 5-point Likert Scale (strongly agree to strongly disagree) social validity questionnaire was sent to DCS's who had SC's completing the questionnaire for over 3 months.
- The questionnaire was created in google forms was sent via email. Responses were anonymous.

Methodology (cont.) & Results

Figure 1

Risk Categorization Questionnaire Levels

Risk Levels	Considerations
Level 2 (Low Risk)	• Client's age/size does not result in physical marks or damage to property.
Level 3 (Moderate Risk)	• Behavior does not result in the need for medical attention but may leave a physical mark • Behavior could result in property damage that could be returned to the original condition
Level 4 (High Risk)	• Behavior could result in permanent property damage. • Behavior could result in need for medical attention

Note. Factors considered in assigning a risk level for high-intensity and dangerous behavior.

Figure 2

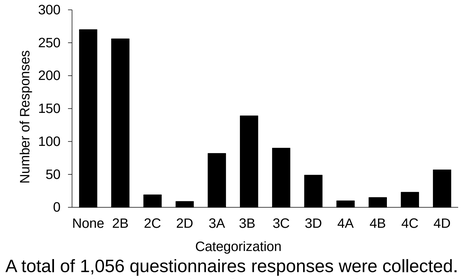
Risk-Level Specific Questions

Level Specific Questions					
Level of High Intensity/ Dangerous Behavior	Magnitude of Behavior	Ability to Predict EOs (Control)	Restrictive Practices	Frequency of Behavior	Need for additional resources

Note. For each risk level specific questions were asked regarding the six categories above. Responses resulted in assignment of a letter notation (A,B,C, or D). In which A is representative of the least amount of risk and D is representative of the highest level of risk.

Figure 3

Risk-Categorization Questionnaire Responses



Note. A total of 1,056 questionnaires responses were collected. The bar graph above depicts the number of responses assigned to each category. "None" means that the client was reported to have no dangerous behaviors.

Table 1

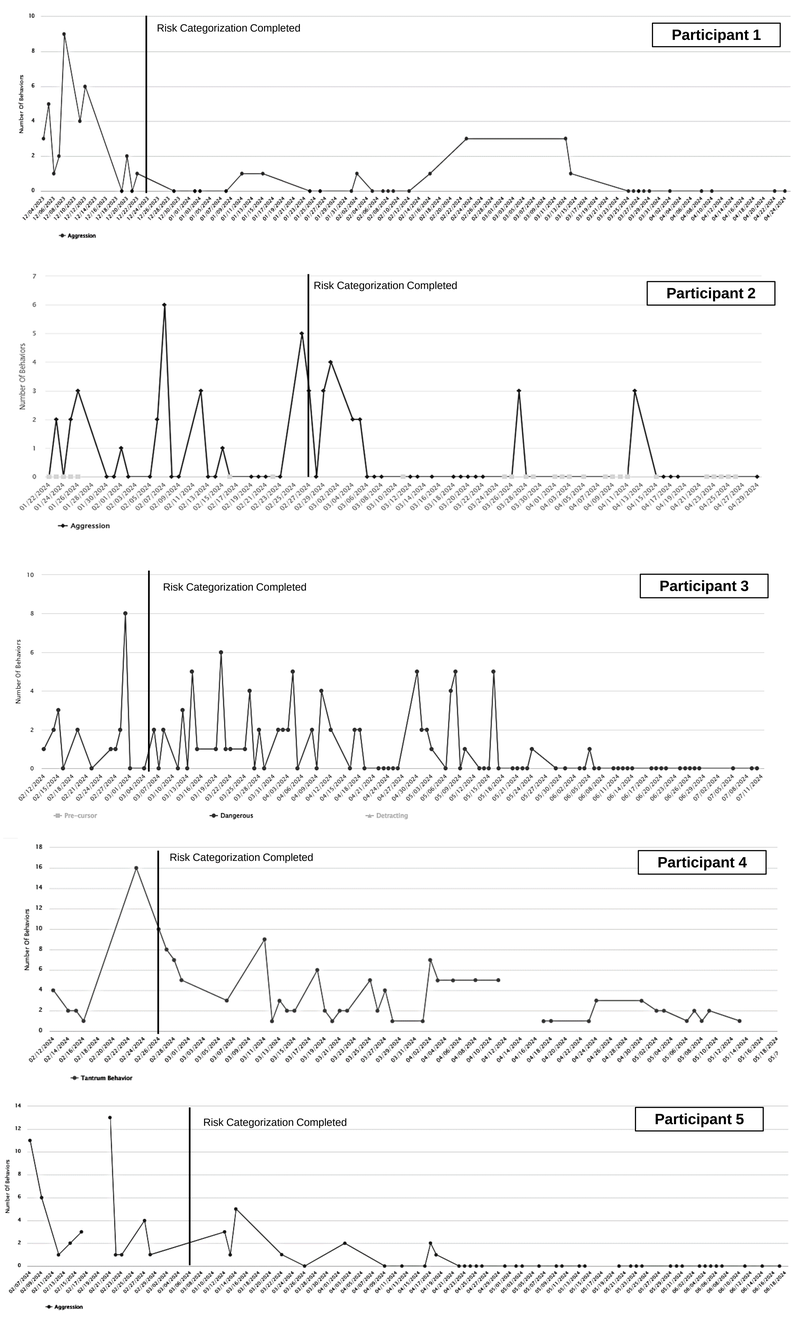
MA Client Categorization and Demographics

Participant	Age	Topography of Behavior	Date Questionnaire Completed	Categorized Risk Level	Additional Supports Provided as Result of Categorization
P1	5	Physical Aggression	12/13/2023	2B	Foundational plan reveiwed and updated, BT assigned trainings
P2	4	Physical Aggression	2/28/2024	3C	Foundational plan reveiwed and updated, BT assigned trainings, DCS ongoing observation overlaps
P3	5	SIB (Head Directed)	3/7/2024	2B	Foudnational plan reviewed and updated, DCS conducted observation overlap
P4	5	Tantrum	2/29/2024	2C	Foundational plan reveiwed and updated, BT assigned trainings, DCS ongoing observation overlaps
P5	5	Physical Aggression	3/7/2024	2B	Foundational plan reveiwed and updated, Clinical review conducted

Note. MA region had five clients that engaged in high-intensity/ dangerous behaviors. Demographics and clinical support provided are reported.

Figure 4

Client High-Intensity or Dangerous Behavior Data

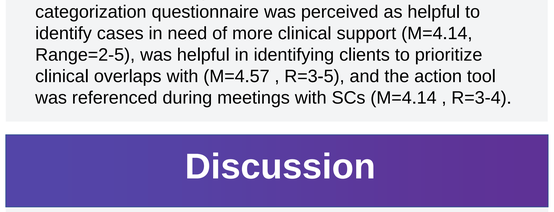


Note. This figure depicts behavior data of MA clients who were identified as having high intensity of dangerous behavior before and after the risk categorization questionnaire was completed.

Methodology (cont.)

Three-Tiered Decision-Making Model

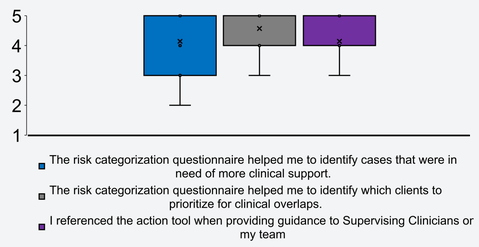
- Step-by-step recommended actions were provided to teams that completed categorization for a client. Based on assigned risk level, recommendations were made regarding clinical considerations, team competencies as well as recommended clinical support. Recommended timeframes for decrease in behavior were provided to consider when to advance to the next tier.



Results (cont.)

Figure 5

Social Validity Questionnaire Results



Note. This figure depicts the responses of the Social Validity Questionnaire sent to DCSs. N=7, response rate 58.3%.

Risk Categorization Questionnaire

- 1,056 responses

Client Outcomes

- 4 out of 5 MA clients showed a decrease to zero instances of the targeted behavior.

Social Validity Questionnaire

- 7 DCS's responded to the Social Validity Questionnaire
- Results were overall positive and indicated that the categorization questionnaire was perceived as helpful to identify cases in need of more clinical support (M=4.14, Range=2-5), was helpful in identifying clients to prioritize clinical overlaps with (M=4.57 , R=3-5), and the action tool was referenced during meetings with SCs (M=4.14 , R=3-4).

Discussion

- Categorizing the risk of a client's high intensity and dangerous behavior was helpful in identifying cases in which additional clinical oversight was required for client progress and to ensure alignment of trauma-informed care.

Limitations/Discussion

- IOA and PI was not collected, therefore it is not possible to determine the reliability of categorization scores or the use of the action tool in meetings as intended.
- Categorization scores were higher if restricted practices were reported or additional resources were utilized, therefore frequency graphs did not consistently depict level of risk.