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A University-Based Social Services Parent-Training Model: A Telehealth Adaptation During the COVID-19 Pandemic

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Abstract

With the COVID-19 pandemic resulting in social-distancing recommendations, many service providers find themselves altering the way they must provide medically necessary therapy. Even with the advent of more advanced telehealth technologies, the implementation of behavioral programming falls mainly on the caregivers of the clients that are served. This crisis brings to light ethical dilemmas and upends the current ways many programs may have been implemented across the world. As a result, a reevaluation of how these services are delivered is in order. This article reviews how a university-based, state-funded service delivery program (USSDP) provided essential and necessary services during the COVID-19 pandemic. Specifically, the purpose of this article is to describe how the USSDP quickly adopted a telehealth care model in a program that previously had not delivered services in this modality. Ethical, contextual, and competency-based factors are reviewed in the context of this organization, followed by a dialogue on broader generalization suggestions utilizing an active support model of care within telehealth restrictions.

Keywords Active support model · COVID-19 · Ethics · Parent training · Telehealth

Following the COVID-19 outbreak in the United States, many social service clients found themselves isolated due to the closure of service agencies. The situation may have been further exacerbated when the government moved to more rigorous evidence-based measures to control the spread of the virus, such as exponentially increasing state-advocated social-

distancing measures. Despite the inherent benefits of these measures in controlling the spread of COVID-19 (Chinazzi et al., 2020), the consequences of this intervention may create significant strains on professional and community support systems.

Previous studies have suggested that prolonged quarantine measures often evoke feelings of fear, loneliness, boredom, and anger among members of the community (Maunder et al., 2003; Bavel et al., 2020). During the current COVID-19 pandemic, schools and workplaces are closed, causing families to be confined to their homes with minimal supports that were available prior to the pandemic. As a result, adults and children are unable to socialize with peers or participate in routine activities (e.g., sports, dance lessons, social clubs), producing a major change in daily life that places unique demands on parents and children alike.

These circumstances undoubtedly provoke professional, clinical, and ethical issues for individuals who continue to provide client services (Robertson, Hershenfield, Grace, & Stewart, 2004). Staff members who have to work during lockdowns and quarantines have reported feelings of guilt, fear, hurt, and social stigma after exposure to infected clients (Robertson et al., 2004). Robertson et al. (2004) completed surveys across 10 individuals previously exposed to other

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Editor's Note

This manuscript is being published on an expedited basis, as part of a series of emergency publications designed to help practitioners of applied behavior analysis take immediate action to adjust to and mitigate the COVID-19 crisis. This article was submitted on April 17, 2020, and received final acceptance on May 4, 2020. The journal would like to especially thank Drs. Amber Valentino and Michael Cameron for their expeditious reviews of the manuscript. The views and strategies suggested by the articles in this series do not represent the positions of the Association for Behavior Analysis International or Springer Nature.

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individuals infected with severe acute respiratory syndrome (SARS) as a result of working in hospitals or attending meetings in hospitals. They found that these individuals reported feelings of loss and anxiety as a result of not being able to continue to interact with others as they had been prior to a SARS diagnosis. Additionally, some participants reported experiencing stigma as a result of others both fearing and avoiding them. Moreover, continued social distancing and isolation may lead to anxiety in addition to impacting caregivers' typical routines of daily living.

Kuhn (1970) described five phases of science and the process occurring when a new scientific model replaces traditional models. For the sake of this article, the current COVID-19 pandemic may be conceptualized as a *crisis* situation in which current models of service delivery are unable to address the current needs of clients, requiring a revolution in service delivery structures and models to support the current and ever-evolving needs of clients involved in these systems. Although the COVID-19 crisis may present a variety of challenges for many individuals in the human service sector today, the crisis situation may actually provide the necessary context to reevaluate current service delivery structures (Acton, Bayntun, Kirby, & Wessely, 2020). This reevaluation may lead to the derivation of more effective care options that persist even beyond the current pandemic. This article provides a clinical model of support for parents and their children when circumstances require altering existing behavioral social programs to fit the current emerging context. Specifically, the goals of this article will be to review a parent support model and discuss its application via telehealth.

Description of the Program

The service delivery model that is evaluated in the current article comes from a research/treatment program at a university that infuses behavior analysis into the social service system. Figure 1 provides details on the administrative structure of the program, which is part of the university's behavior analysis department. The university-based, state-funded service delivery program (USSDP) is funded by the Title XX Purchase of Service Contract and the Illinois Department of Public Aid and delivered by the behavioral sciences unit at a large Midwestern university. The USSDP works directly with, parents indicated for the neglect and abuse of their children and utilizes a molar or ecological approach focusing on the broader context of the parent behavior in question (Lutzker, 1984). This includes the consideration of contextual factors influencing parent behavior, such as demographics, employment status, and poor adult interactions. In addition to examining the functional relations between parents' behavior and contextual variables, this treatment model also evaluates parent behavior and how it affects others in the environment (e.g.,

clinical assessment of the many factors within the whole context that influence the parent's behavior of interest; Lutzker, 1984).

The treatment model used within this program stems from the proposition that factors influencing problems as severe as child abuse and neglect need to be addressed by a durable functional approach that considers the larger context and how that affects the behavior of interest (Lutzker, 1984). This view differs drastically from other parent-training models based on specific stimulus-response-stimulus relations regarding parent target behavior in that it focuses on the broader context of parenting and its influence on the family. Previous interventions stemming from this model have produced effective outcomes in areas that include reducing disruptive behaviors on buses (Greene, Bailey, & Barber, 1981), increasing cleanliness in homes (Watson-Perczel, Lutzker, Greene, & McGimpsey, 1988), increasing parent implementation of childcare routines (Greene, Norman, Searle, Daniels, & Lubeck, 1995), increasing home safety (Barone, Greene, & Lutzker, 1986), improving parent-child social interactions during shopping trips (Clark et al., 1977), and enhancing families' social and educational interactions during restaurant visits (Green, Hardison, & Greene, 1984). Services of this nature are important for the improvement of family interactions and the long-term preservation and reunification of families who have experienced a history of abuse and neglect. As a result, the modes of program delivery have to be reevaluated in the wake of the COVID-19 crisis to match client needs.

Client referrals for this program come from five state and not-for-profit agencies within a specifically defined rural area. When a referral is received, an investigation is conducted to verify Title XX eligibility. Two main factors are used to determine a family's eligibility for Title XX services. The first is the family's protective status, which is determined by a suspicion of abuse or neglect as ascertained by a formal investigation. The second is the family's socioeconomic status, which is determined when mothers or fathers lack support in parenting their children and present with a very high risk for potential child abuse (Smith, Hanson, & Noble, 1974) that warrants preventative services.

Once eligibility is verified, the case is assigned to a counselor who schedules a meeting to review client files with the caseworker. After the file is read, an introductory meeting is scheduled with the caseworker and the clients in their home. Following this initial meeting, counselors schedule follow-up meetings during which assessments of needs are conducted in the clients' homes. These assessments address physical home conditions, household routines, and family interactions. Parent-training goals are derived from these assessments, and counselors review these goals with parents to ensure parents agree with the identified treatment targets before parent training begins. Some common parent-training goals within the program

Fig. 1 Hierarchy of the USSDP and the general duties of each position
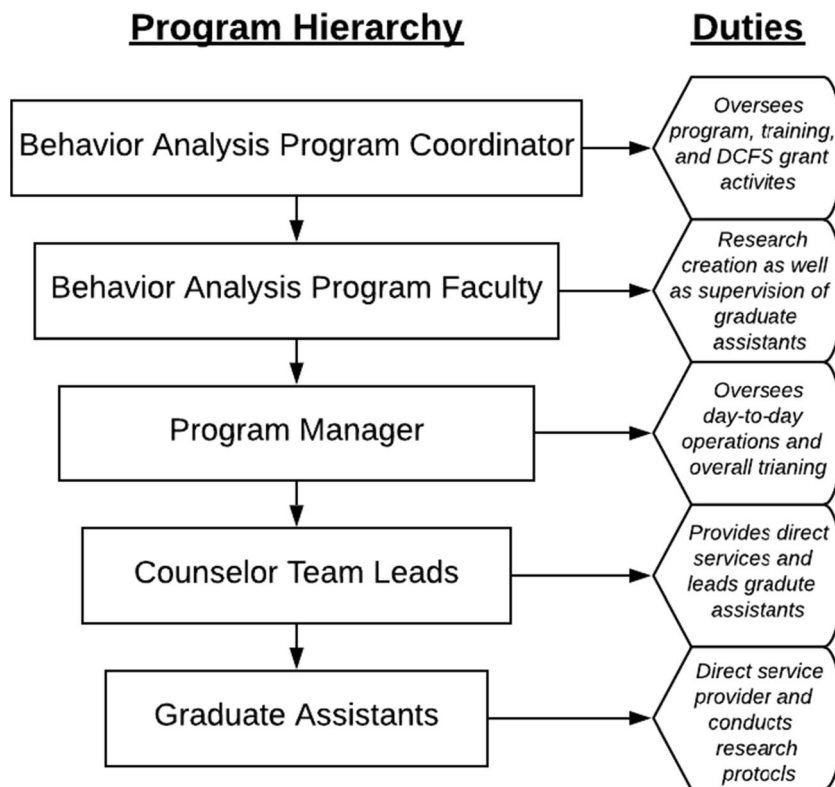
include safety and supervision skills, establishing time in, parent communication skills, bedtime routines, spoon-feeding skills, implementing time-out, and child management skills. Baseline data are collected prior to intervention, and parent progress on parent-training goals are monitored subsequently after training begins. Continuous data monitoring allows parent targets to be modified, and procedures are altered to achieve program outcomes of reuniting families.

Behavior Intervention via Telehealth

In the current context, the World Health Organization, the Centers for Disease Control and Prevention, and state officials advise against close physical contact in an effort to mitigate the spread of COVID-19. Though applied behavior analysis (ABA) practitioners have generally been allowed to continue practicing, as ABA is deemed an essential service, the high rate of contagion required changes to service delivery models to ensure the safety of clients and staff. Behavior analysts are challenged to meet the needs of clients under these circumstances in which face-to-face interactions are difficult or impossible.

Tharp and Wetzle (1969) faced a similar challenge. These authors provided behavior consultation to families, professionals, and residential staff located throughout rural southern Arizona in the mid-1960s. They did not have face-to-face contact with many of their clients or with their intervention

collaborators. They developed a distance-consulting model that was subsequently replicated in several other western states, Alaska, and Hawaii. At that time, the concept of applying the principles of learning to address socially significant behavior problems was relatively new. Skinner had just published *Science and Human Behavior* (1953) one decade earlier, and even telephone service was limited. Tharp and Wetzle (1969) used targeted and simplified interventions, a streamlined process of assessment, and treatment planning and intervention that relied heavily on intermediaries with direct access to clients. They reported that 120 of the 135 target behaviors (among 45 clients) improved significantly (50% of baseline).

The design of distance behavioral consultation in the natural environment can be informed by Tharp and Wetzle's (1969) work. These authors concluded that effective interventions in the natural environment depended on several factors, including (see Figure 2 for further details and support):

- targeting a small number of clearly defined and measurable behaviors;
- assuring that mediators have control of reinforcers that are important to the client;
- using straightforward and simple interventions that are readily communicated to mediators and easily understood by them;
- providing timely reinforcement of mediators' correct intervention; and

Fig. 2 General decision model for considering changes to current programming when applying to a telehealth model based on Tharp and Wetzel's (1969) suggestions
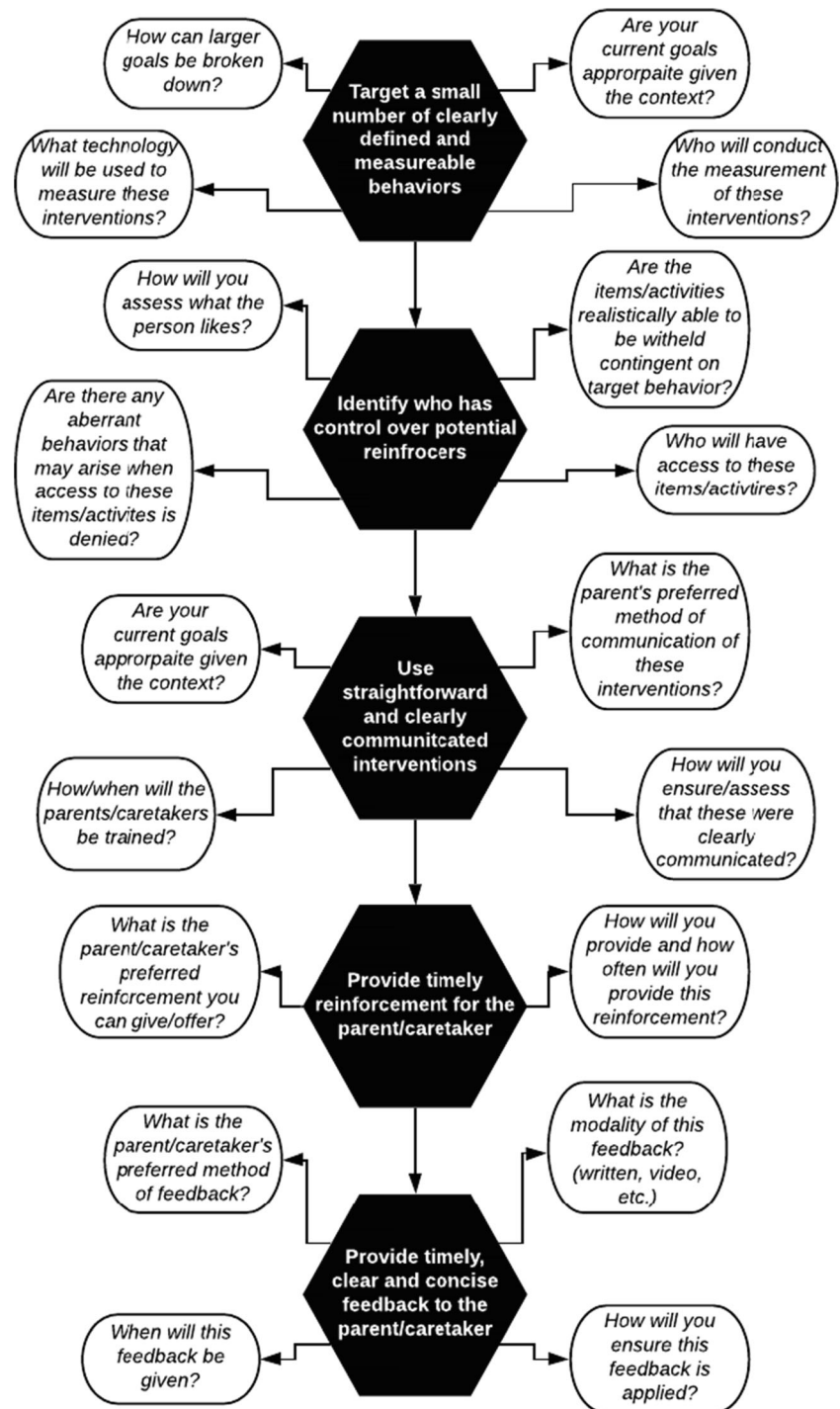
- providing timely and constructive feedback when mediators are not performing interventions correctly.

Not surprisingly, these are the same elements that would characterize a competently designed behavioral intervention. The behavior analysts' absence from the scene of intervention and the use of cumbersome communication (e.g., landline telephone) highlighted the need for clarity and simplicity of intervention techniques, but these characteristics are always desirable, especially when designing interventions that will be implemented by relatively inexperienced and sparsely trained personnel.

More recently, Lee et al. (2015) have demonstrated the conditions under which functional assessment and functional communication training conducted at a distance and suggested that a high level of technical skill is required for interventions to be successful. Staff members' and parents'

competence in telehealth technologies (Zoom, GoToMeeting, Doxy.me, etc.) cannot be assumed. Providing therapeutic services in the scope that the service provider was trained for is one repertoire, and technology is another; separate repertoires need to be focused on in order to deliver quality care to individuals. Competency with the application of various telehealth technologies is another separate repertoire that needs to be focused on to ensure clients receive quality services. Given these concerns for providing quality services via telehealth is not simply applying the goals and protocols the way they were prior to the COVID-19 pandemic—something that our agency had to consider when moving forward with services in a different treatment modality, while utilizing aspects of the active support model.

Ethical Considerations

The General Context

The USSDP program was designed to address three main objectives. The state protective services agency was in search of a trusted service provider to contract with to invest the Title XX funds for which they were responsible (Lutzker, 1984) in order to support the population of children and their families in need in the area. Additionally, the university needed external funding opportunities for students, as well as direct training opportunities to support students who were receiving an education in related fields of study. The joining of these factors contributed to the development of the current program and its administrative structure. Currently, the program has about eight graduate students working in the field providing contextually based behavioral treatments to parents with the ultimate goal of reuniting families separated by a parental history of child abuse and neglect.

Safety Considerations

On March 9, 2020, however, the governor of Illinois declared all counties in the state a disaster area and instituted a shelter-in-place decree beginning March 21, 2020. Most residents of the state were now required to stay home, and nonessential businesses were requested to cease operation. Schools were also requested to close physically and modify the delivery of educational materials to avoid physical contact. Staff members who provided human services were, however, exempt from this decree and were still required to continue the provision of essential services targeted at rehabilitation—our program included. Other contextual factors present included the modification of university activities requiring all classes to be delivered via an online format, which meant that students did not have to be physically present to participate in their educational activities, including the training course for the state-funded service discussed in the current article. Many students had left campus as a result of spring break and traveled to other parts of the country in the week prior to the shelter-in-place directive. While on break, students may have had an increased risk of exposure to the virus, and upon their return to the agency, they could potentially place other staff members and clients at risk of contracting COVID-19. Consequently, the possibility of contacting COVID-19 may be increased by exposing clients to students who may have been infected due to recent travel for spring break. Additionally, potential harm could occur if the program made the decision to stop services entirely due to the COVID-19 crisis. This resulted in an ethical challenge requiring the program to adapt in order to protect clients and professional staff.

Residents of Illinois were also permitted, according to this decree by Governor Pritzker, to leave their homes at their own risk to access these essential services. This situation presented an ethical dilemma for program officials, who had to balance their ethical principles of beneficence with ethical obligations of nonmaleficence in the wake of a serious global pandemic such as COVID-19. The program had to consider important ethical values related to the fairness of service provision to all clients in light of the fidelity in adhering to their obligations to provide these services targeted at reuniting families. With multiple response options to consider with varying consequences for each, the program had to carefully evaluate the consequences of each response option to ensure that the chosen course of action would foster beneficence while decreasing nonmaleficence. See Table 1 for consideration areas and descriptions of actions taken within the current context.

While the program addressed the aforementioned contextual concerns, several important ethical principles were utilized in the decision making that went into the COVID-19 response, first of which was the ethical principle of *nonmaleficence*, which stresses an obligation to do no harm to others (Millard & Rubin, 1992). This includes reducing or removing conditions inherent in situations that may place individuals at risk of contracting harmful outcomes as a result of exposure to such situations. Conversely, *beneficence* stresses the need to foster circumstances that contribute to the welfare of others by conferring benefits and promoting good outcomes (Millard & Rubin, 1992). This helps to balance out doing no harm while promoting the greatest good possible given contextual factors.

In addition to these principles, the ethical principle of *fairness* suggests that all parties involved in treatment need to be treated equally (Millard & Rubin, 1992). In this case, two or more parties may be treated differently, one receiving more services than the other; however, such a decision may be considered a fair decision as long as the treatment received by both parties produces a fair opportunity to benefit for both, as is dictated by their specific treatment needs. That is, it is possible to provide families differing amounts of support in the current climate based on clinical need, as long as the levels of support provided to each family produce clinical benefits for each family. A final principle is the

Table 1. Ethical consideration areas for USSDP

Consideration Area	Descriptions
Safety	Health: Does the current service delivery model increase parents' risk of contracting COVID-19? Does the current service delivery model increase staff's risk of contracting COVID-19? Client outcomes: Would service goals be compromised if not worked on? Do the services being provided match parent needs in the current context?
Telehealth	Access to technology: Do parents have access to the necessary technologies for telehealth service implementation? Do staff have access to the necessary technologies for telehealth service implementation? Competency: Do staff know how to modify goals given the new treatment modality? Can parents implement behavior plans and manage technology at the same time? Training: Do parents need training on how to use the telehealth technology you have chosen? If so, how will you do this? Have staff received training on how to use the telehealth modality? Modality usage: Are you taking actions to ensure that client visits are taking place in the best context to facilitate open and honest parent interactions? Do parents need to be provided session agendas ahead of visits? Do parents need to be debriefed after each session (what worked well, clarifying questions, future session adaptations, etc.)?
Parental	Knowledge of programming: Have parents received training on prerequisite skills necessary to implement behavior plans being implemented? Can programs be implemented if parents have to manage telehealth technologies and implement behavioral programming?

concept of *fidelity*, which focuses on the promises made by the clinician to the clients with which he or she is working (Millard & Rubin, 1992). For example, in the case of the current agency, the families are relying on the providers' commitment to providing effective and appropriate services in order to be reunited with their children.

The family's current living situation was another important contextual factor that needed to be considered in order to ensure appropriate service delivery. Family custodial arrangements, for example, dictated differentiated service provision. Environments differed based on whether the family had access to their children in the wake of abuse or neglect charges or if the children were separated due to a history of abuse and neglect. In both cases, the program still provided support services; however, in the case of separated families, services needed to be provided to the parent on a one-on-one basis with frequent visitation by the children to ensure that parents were able to apply the skills taught in the necessary contexts with their children. Given the current COVID-19 crisis, the telehealth model of service delivery had to be modified to meet each family's individual needs.

Telehealth Considerations

An obvious difference between the delivery of telehealth services and in-person treatment is that service providers are not able to have direct contact with clients when providing telehealth services. This lack of physical contact between the service provider and the client diminishes the service provider's ability to observe the minor physical (e.g., body language) and verbal (e.g., vocalizations) cues that are a part of the various stimulus streams during social interactions. This could potentially affect the identification of important contextual cues (e.g., frustration and discomfort with programming or feedback delivery), as well as the other necessary contextual variables that may influence the nature of social interactions, and psychological assessment delivery completed via telehealth technologies (Luxton, Pruitt, & Osenbach, 2014). Nevertheless, the current authors provide clinicians with some helpful suggestions on how to create the necessary environmental conditions to support effective interpersonal interactions during assessment delivery via telehealth. In the aforementioned contexts, our program evaluated the benefits of continuing treatment and adjusting session structures to create the necessary environment for effective interactions given the risk of not providing services during the physical limitations set forth in the COVID-19 crisis. Our program utilized the clinical expertise available and outlined specific steps to engage in prior to the session to ensure that the environment is created for an effective telehealth visit. In preparing for sessions, the clinician needed to include:

- a detailed description of the session structure prior to the session;
- a review of information on how to access the platform for the session;
- discussions on how to identify the right physical environment with or without children;
- a review and discussion regarding goals for the session;
- modification of language for interview assessments to fit telehealth delivery of interviews; and
- a review of data collection sheets and feedback tools used during the session.

Consideration was also given to conceptualizing the telehealth visit to clarify or elaborate on the information provided, such as by providing the parent a debrief of sessions, reflecting positively on things completed correctly during the session, and providing opportunities for parents to ask clarifying questions and provide feedback.

The principle of fairness was applied in this situation when we decided to take steps to create an appropriate environment for telehealth service delivery. Additionally, the principle of fidelity was applied in this situation when we took active steps to ensure that the clinical relationship between clients and intervenors was preserved by proactively creating and fostering a safe and conducive environment for interactions during sessions. Given the application of these ethical principles, the service intentions may be deemed contextually sensitive considering the use of telehealth technologies. A more comprehensive empirical evaluation of the effects of these considerations may be provided by data on overall parent competence in the application of parent training goals.

Parental Considerations

Scope of competence is described by Brodhead, Cox, and Quigley (2018) as the necessary didactic education, training, and supervised experience in a specific area, as well as the ability to demonstrate successful and independent outcomes. Competence is an important variable to consider in the delivery of services to clients, especially those services delivered via telehealth technologies. In a study conducted by Machalicek et al. (2016) that evaluated the use of teleconferencing to facilitate behavior consultation with three parents of school-age children with autism spectrum disorder, the researchers implemented treatment in two phases with parents as interventionists via telehealth technologies: The first phase consisted of a functional analysis of target behavior(s), and the second phase consisted of a brief multielement treatment comparison consisting of antecedent interventions, functional communication training, and differential reinforcement of alternative behavior. The results of this study suggested that behavioral consultation via telehealth was effective in conducting a remote assessment and developing an effective

treatment protocol. Some parents, however, did require more verbal prompting to implement the procedures correctly, and as a result, more sessions were needed for these parents. Given this individualization based on observable parental competencies, the researchers encourage additional face-to-face training with some parents to support effective implementation of trained procedures, implemented via telehealth coaching where possible.

In evaluating the ethical concern of parent competence, we weighed the benefits of modifying programs to fit a parent's level of competence against the risk of not training specific parents due to their limited skill repertoires. The apparent benefits of working with parents and modifying training targets to encourage adherence to procedures appeared to outweigh the risks involved with not supporting these same parents. Consequently, it appeared more useful to adapt our training targets in light of the COVID-19 crisis to fit the needs of parents within the current context. Fairness was exercised under the current circumstances when procedures were adopted to match parent skill levels. Skinner (1968) alluded to a similar concept when he suggested the learner was always right, and encouraged the adaptation of teaching procedures to ensure that the scientist achieves his or her pragmatic goals. By creating goals and environmental factors that took parents' level of competence into consideration, the behavioral repertoires required to reach these goals were not hindered by non-person-centered programming. Additionally, the principle of fidelity was exercised by maintaining our ethical obligations to clients irrespective of skill level. This decision further fosters the program's values of reunifying families through parent support and training. The current model here has been created based on the previously mentioned research and ethical principles that drive quality care. This model can potentially be expanded to other behavioral service providers, and further considerations will be reviewed in the following sections.

Another consideration in this area was parent and staff competence with regard to the technology being utilized for service delivery via telehealth. Steps were taken to sample client and staff familiarity with various technologies via interviews prior to applying telehealth services that use these technologies. In the event that a staff member or parent was not familiar with a technology, a quick task analysis was developed for use as a training tool so the individual could acquire the necessary competencies for the technology's use.

Parent competence in assuming multiple roles was also considered within this context. Under the current circumstances, parents will be required to replicate interventions described, manage technology for telehealth visits, and report data via interviews where appropriate. It is important to consider all the previously discussed ethical principles when determining how much parents can accomplish during a single session. In the current context, we decided to let our

evaluations of parents' ability or competence be determined by our data, with plans to change procedures if parents are not able to fulfill responsibilities in specific areas as indicated by data reported by counselors.

The Model's Adaptation to Telehealth

In adapting to the needs of the current context, the active support (Mansell & Beadle-Brown, 2012) model was adapted for use with the current parent-training model. *Active support* emerged as a system of training, consultation, and assistance to enable and empower people with intellectual and developmental disabilities (IDDs) to actively participate in daily life. It has evolved over the past 40 years and has been widely adopted in the United Kingdom. It recognizes that, when supported actively, people with IDDs are able to participate in meaningful activities and relationships. This focus is compatible with ABA and the model that our agency applies to all families we serve. Active support provides concrete guidance to caretakers, as it is commonly recognized that, in the absence of explicit structure and guidance, caretakers tend to recede to a role that is dependency producing and detrimental to the developmental growth of the individuals they support. A review of available evidence (Hamelin & Sturmey, 2011) concluded that this system of support meets the criterion as a "promising" (Chambless & Hollon, 1998) treatment.

Though not tested with families and children, this model has implications that are compatible with the delivery of ABA services to support families in the natural environment, especially in the wake of the COVID-19 pandemic. Notably, it and practices. Mansell & Beadle-Brown (2012) prominently acknowledge the influence of ABA, particularly in the form of positive behavior support (Carr, Dunlap, Horner, & Koegel, 2002), on its development.

Active support guides caretakers to optimize their interactions to maximize their clients' participation in naturally occurring and meaningful activities, including social interactions with others. Through active support, individuals gain opportunities to contact naturally reinforcing contingencies and thereby acquire and strengthen behavioral repertoires that are

useful to them in everyday life. Additionally, this model equips caretakers to use four avenues for influencing their clients. The principles utilized in this approach include the following: (a) every moment has potential, (b) little and often, (c) graded assistance to ensure success, and (d) maximizing choice and control. All are grounded in ABA principles and have applicability to the parent-child relationship and the potential to enhance child welfare and development. Table 2 provides details on the various active support principles discussed next.

Every moment has potential highlights the fact that the natural environment and routine everyday events provide opportunities for incidental teaching (Hart & Risley, 1975). Accordingly, whenever child-parent interactions occur naturally in unstructured situations, teaching can occur. For instance, when a child is frustrated by difficulty tying his or her shoe, the adult has an opportunity to model effective shoe tying, set the child up to succeed, and reinforce successful tying with praise. Similarly, an adult can prompt and encourage polite asking by a child in instances in which the child has an obvious need but is unable to satisfy it. With an awareness of sensitivity to the principle of *every moment has potential*, every activity of the day and every parent-child interaction become an opportunity for teaching and learning.

Little and often recognizes that children have short attention spans and may not always remain interested or motivated long enough to complete a task or activity that their parents decide is important. Understanding this principle encourages parents to be patient and to be satisfied with a "good effort," instead of insisting on perfect task completion. This principle says to the parent, "Take what the child gives you, and build on it." By using this principle, the parent is in a position to successively shape behavior to ultimately match expectations.

Meaningful activities and social skills ultimately are maintained because they produce natural consequences that are reinforcing. By using *graded assistance to ensure success*, parents ensure that their children experience the naturally reinforcing consequences of their actions even though their skills may be insufficient to achieve success without help. Thus, parents may use prompting or modeling techniques to help their children succeed. By using this approach, children

Table 2. Active Support Principles

Principle	Descriptions
Every moment has potential	Identify every interaction as a possible opportunity to teach your children adaptive skills.
Little and often	Introduce new opportunities in small doses, and try to end on a good note.
Graded assistance	Provide the right amount of structure, verbal direction, and supplemental assistance to occasion an action or engagement. Consider the use of natural cues, gestures, clear verbal directions, visual cues, models, and partial physical or full physical support.
Maximizing choice and control	Encourage age-appropriate communication of preferences, needs, and interests. Consider providing experiences that allow your child to have many alternatives to choose from.

are "set up" to succeed and are spared the negative experience of failure. Parental praise for success is encouraged, but the important component of this approach is that it brings children into contact with the natural (reinforcing) consequences of their actions. For the purposes of our program, we modified this principle to fit within our program's values and named it "helping children to help themselves."

Choice and control are important skills that can be fostered by parent-child interactions. *Maximizing choice and control* is not a call for permissive parenting. Learning to accept "no" and negotiate is an important skill and should not be neglected. Parents should be instructed as to when it is appropriate and effective to "control" their children's behavior by saying no, by setting boundaries or limits, and by depriving the child of items or access. These measures should only be applied when the parent determines that (a) the objective (in terms of the child's behavior, welfare, or safety) is important and necessary, (b) the parent has control over the consequences he or she is specifying, and (c) the parent has the patience and stamina to withstand his or her child's potential resistance.

Parents can also foster choice and control by thoughtfully offering choices whenever that is possible. By making daily routines and concrete plans that are effectively shared with their children, parents can also create opportunities for their children to exercise appropriate choice and control. Active support recognizes that unless procedures and practices are operationalized, they are not likely to be carried out reliably. It is important to ensure that activities and events are consistent and predictable in family life as much as possible. Given the recent suggestions on social distancing and isolation in response to the COVID-19 pandemic, creating these systems of support is paramount and, in many cases, the only type of behavioral programming that may be implemented for ABA agencies using telehealth platforms.

Generalization Considerations

Many aspects of active support (Mansell & Beadle-Brown, 2012) are represented in our organization that mainly include the parents and caretakers in creating environments of safety and success for their children. Given the limits of face-to-face interaction, and how much of the behavioral work is placed on the parents, it appears that adapting and utilizing this model may present alternative clinical avenues for more effective care during the pandemic.

For our program's purposes, some active support elements were modified to fit program-specific values. For example, the principle of "graded assistance" was modified to "helping children to children to This change was made to emphasize the importance of fostering independence with children in

households whenever ethically possible. This value is encouraged to ensure the elimination of unnecessary prompts and cues as children's skill repertoires develop (Kindermann, 1993). Additionally, the principle of "choice and control" was modified to "let their voices be heard" to foster parents' mediation of reinforcement for the use of age-appropriate functional communication skills. Figure 3 is a general visual conceptualization of our approach within the various contexts described throughout this article. By considering and mindfully adapting to each of these contexts, we were able to adapt to the wider context of the COVID-19 pandemic.

Active support recognizes that unless procedures and practices are operationalized, they are not likely to be carried out reliably. It is important to ensure that activities and events are consistent and predictable in family life as much as possible. For this reason, the active support model also promotes the use of daily active support plans (Mansell & Beadle-Brown, 2012). By learning to create and use daily activity plans, parents have the opportunity to learn and practice planning skills and to ensure that opportunities for actively supporting children are not missed. Daily active support plans are organized around natural "anchors" in the day, such as waking up, going to bed, and having meals. Other milestones in a child's day may include departing for school and returning home and parents leaving home for work and arriving home. Other points of reference may be bathing, dressing, the time of favorite TV shows, or the availability of certain activities (e.g., trips to the playground or bike rides). Daily active support plans should be built around these events and designate predictable opportunities for parents to be attentive to and supportive of their children. As mentioned by Szabo, Richling, Embry, Biglan, and Wilson (2020), given that children and their families are quarantined at home for an unknown amount of time, providing this structure in the day (which typically would have been provided by school and work schedules) may be a key component in assisting families via telehealth.

It is advantageous to work out daily active support plans on a weekly basis, and this should cover selected regular activities, including daily milestones, personal and self-care activities, social activities, and appointments. A large calendar should be used to note these activities during each day of the week. Each morning or evening, parents should review the upcoming day's activities and decide among themselves how to maximize the benefits to their child of each of the scheduled activities. Once this is done, parents should note which parent or caretaker will support the child in accomplishing a particular desirable outcome, which is also noted—all of which can easily be done on a weekly basis while providing services via telehealth.

The daily activity support plan can be as formal or informal as needed to be successful. Its regular use will help keep parents alert to the opportunities that each day presents so that they are in a position to provide active support through the four avenues

Fig. 3 The wider adaptive contextual responding for clinical care as it relates to the COVID-19 pandemic. The various areas considered in responding were the following: safety, telehealth, and parental
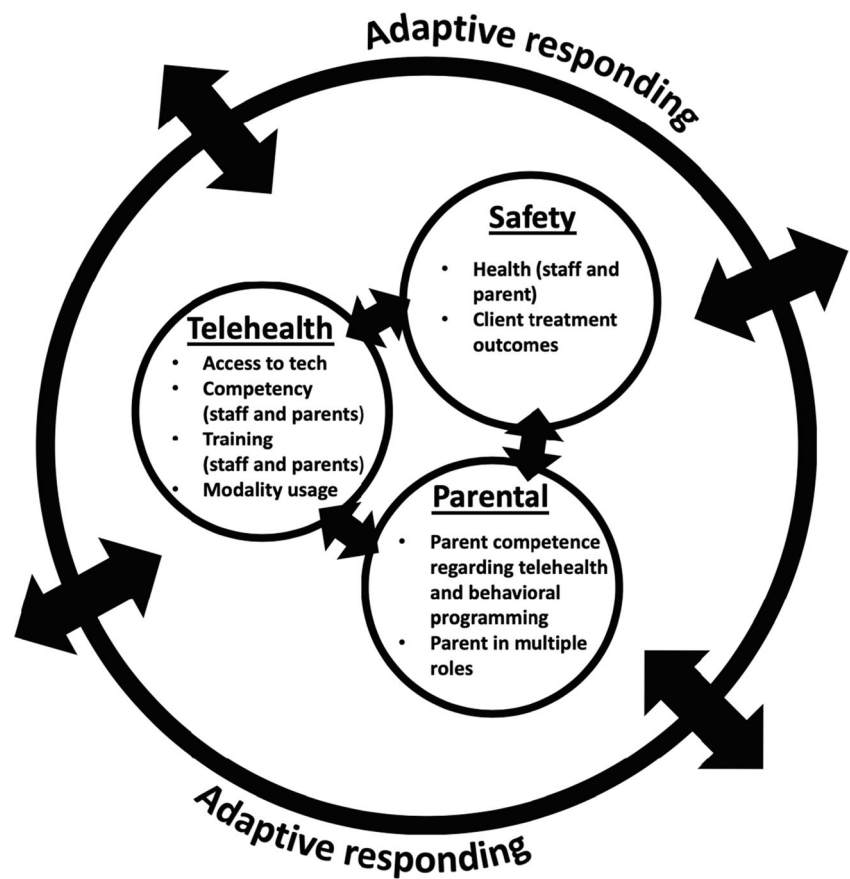
identified previously. By completing these avenues, parents are empowered to work with their children, who benefit from an enriched, successful environment in order to promote quality opportunities for development (Szabo et al., 2020).

Conclusions

We do not have all the answers—no one does. The current context is novel and rapidly changing, requiring flexible action to adapt to the new contingencies of reinforcement as they emerge. For the same reasons, our proposed model lacks data. In sharing our problem-solving process, we welcome other behavior analysts and researchers to evaluate this process with us, to provide the necessary empirical evidence to support effective action during this difficult time. We also encourage empirically validating alternative support structures such as active support and using insights from Tharp and Wetzel (1969) in the delivery of behavioral services via telehealth.

It is also important to remember that the behaviorist view includes assumptions of anti-representationalism (e.g., reality is shaped by one's immediate social environmental context), and as such, it considers the action of the behavior analyst—with all of its assumptions, ideologies, and goals as it is shaped by the verbal community of behaviorism—as part of the analysis (Leigland, 2010). This means that as behavior analysts, we are also susceptible to contingencies of reinforcement in our practice and research activities, leading us to focus on the topics that are important to us given the current contexts. Especially under the emerging context of COVID-19, we encourage behavior analysts to pay close attention to this and remember the pragmatic values of our science when intervening or conducting research in this context. Additionally, we should take care to remember that when the COVID-19 pandemic is over, the protocols set up under this context will remain, and as such, we should consider the generalizability in a nonpandemic context.

Finally, the current article provides some suggestions that clinicians can use after making modifications to fit their own unique contexts. We share the caution and suggestions made by Rodriguez (2020) in that many ABA programs are not easily switched to telehealth services (e.g., discrete-trial teaching run by registered behavior technicians), and perhaps using their model for assessment would be a valid first step before embarking on service modality shifts. This article was written in an effort to give one example of how a service organization is handling the current COVID-19 pandemic while considering the various ethical, clinical, and practical considerations in doing so. We hope that others may take the same thoughtful care while shifting service modalities during this unprecedented time.

Compliance with Ethical Standards

Conflict of Interest   The authors declare there are no conflicts of interest.

Ethical Approval   All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent   No informed consent was collected for this article as no human subjects were involved in the research for the preparation of this manuscript.

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