

Academic and Behavioral Consultation

Although the pediatric neuropsychological evaluation and intervention approach using the Cognitive Hypothesis Testing (CHT) (Hale & Fiorello, 2004) model naturally leads to intervention, some children and adolescents will come to the CTBL with sufficient data from other sources (e.g., previous evaluations) to only require consultation to address their academic or behavioral needs. Therefore, it is not required that children and adolescents undergo a comprehensive pediatric neuropsychological evaluation before this service can be provided. Whether it is academic, social, or behavioral consultation, we are here to meet the needs of your child or adolescent.

Cognitive Hypothesis Testing



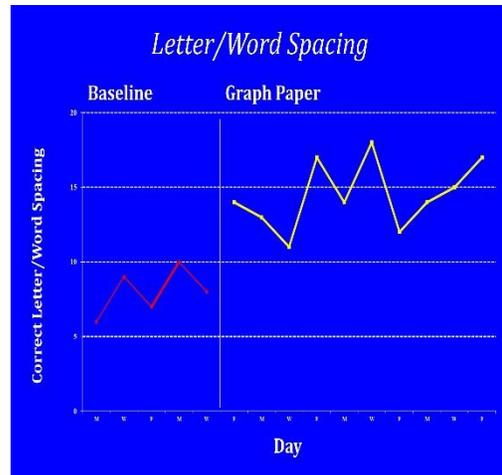
The focus of the academic and behavioral consultation is to use an indirect service delivery approach, which means the consultant primarily works with parents, teachers, and/or other professionals who carry out the intervention for the child or adolescent. The consultation model is the collaborative problem-solving approach. This problem-solving type of consultation model, advocated by the National Association of School Psychologists, requires four steps:

1. **Problem Identification** – During problem identification, the consultant works with the consultee to list all potential targets for intervention, and hierarchically arranges them in order of importance. They then decide which problem to target (it is best to work on one thing at a time), and operationalize the problem so it is in observable and measurable form. This makes it easier to measure for both baseline and instruction/intervention data.
2. **Problem Analysis** – For problem analysis, the potential causes of the problem (including neuropsychological) are considered, including the setting events, antecedents, and consequences for the problem behavior are considered, including neuropsychological causes. For instance, one of the characteristics for children with ADHD is they are inconsistent in their



performance of a skill, so the traditional skill deficit vs. performance deficit consideration must be evaluated carefully. During intervention, the antecedents and/or consequences can be modified, as this is one way behavior change occurs.

3. Plan Development/Implementation – This is a phase where the team first brainstorms possible evidence-based instruction and/or intervention. The consultant and consultee then decide on what the instruction/intervention will be, when and where it will occur, and what types of contingencies are put in place. They pick a method for monitoring the instruction/intervention so decisions are data based. The instruction/intervention is then typically carried out by the consultee, but the consultant can provide support for the instruction/intervention or even carry it out if the consultee feels it is beyond their capability. Although there are different types of single subject designs that are used to monitor treatment effects, the typical intervention includes a collection of baseline data first, and this is followed by the intervention data collection. A goal is set, and then data are collected.



4. Plan Evaluation/Recycling – As the instruction or intervention is being carried out, typically the consultee gives the data to the consultant on a regular basis, who scores and plots it on a graph. Regular decision points are examined, and if the instruction or intervention is leading to desired improvements for the child or adolescent, the instruction or intervention continues. If the goal is met, the instruction/intervention is stopped. If the instruction/intervention is not achieving the desired improvements, the team agrees to modify the intervention, which is called *recycling*. Although this could mean a completely new instructional or intervention approach, it is more typical that the current approach in place needs modification in the antecedents, method, and/or consequences, so the team just has to “tweak” the approach currently being used.

