Supporting Individuals with Autism in Adult Life: Challenges, Risks and Potential.

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Presentation Notes

As a general rule I try to avoid using the terms "high functioning" or "low functioning" to describe where someone falls on the autism spectrum. The reason is that these terms often describe someone's degree of vocal verbal behavior rather than any actual level of functioning. So instead I try to use "high verbal" or "low verbal" which I think is more accurate.

With that, a central challenge in preparing a presentation on ASD and Adulthood is the complexity of the topic and the diversity of the autism spectrum. As such, when working in this area the assessment of individual competencies, interests, deficits, excesses, preferences, dislikes, etc. is essential.

How most people view the universe of potential opportunities, challenges and outcomes for adults with ASD/ID

Not necessarily small, but limited to a relatively confined space.
The biggest challenge?

The potential for most adults with ASD to lead active, included, productive and happy lives is more often limited by the vision of those supporting them than by any of the limitations associated with their status as a person on the autism spectrum.

But...

Current State of the Transition to Adulthood Process in Practice

Outcomes in Adulthood for Adults with Autism Spectrum Disorders


- Shattuck, et al. (2012) conducted a comprehensive literature review regarding original research on services and interventions aimed at supporting success in work, education, independence, and social participation among adults aged 18 and older with an ASD published between 2000 and 2010.
- They concluded that the evidence base about services for adults with an ASD is underdeveloped and can be considered a field of inquiry that is relatively unformed.


As a result of analyzing data from the NITS-2 it is clear that young adults with autism have a difficult time following high school for almost any outcome you choose - working, continuing school, living independently, socializing and participating in the community, and staying healthy and safe. To complicate matters, many of these youth begin their journey into adulthood by stepping off a services cliff. Access to needed supports and services drops off dramatically after high school – with too many having no help at.

Research on outcomes in adulthood is growing, but findings remain inconsistent and often conflicting. Contradictory reports abound as to how many adults with ASD achieve good outcomes and this is lack of agreement on how to measure outcomes. Nevertheless, despite lack of agreement between studies, overall outcomes for adults with ASD in terms of jobs, relationships, independent living and mental health are considerably poorer than for same age peers. Knowledge about factors that are associated with good, or poor, social and psychological outcomes remains very limited, with few studies considering family, school or wider social influences.

Results based on a comprehensive survey of 3,520 working-age adults (18-64 years) with ASD who were no longer in high school and were using DD services. Notable findings included:

- Paid, community-based employment was the least common outcome for adults with autism spectrum disorder (ASD). Only 14% held a job for pay in the community.
- Over half (54%) participated in an unpaid activity in a facility (where most other workers had disabilities).
- One-fourth (27%) had no work or day activities, in either community-based or facility-based settings, in the two weeks prior to the ACS.
- Almost half (49%) of adults with ASD lived in the home of a parent or relative. Many of those who lived with their families had been there for more than 5 years.
- One-fourth (27%) lived in group homes with up to 15 people who also had disabilities. It was uncommon for adults with ASD to live in institutions.

Continued Poor Outcomes May Be Due To a Disconnect Between the Educational and Adult Services Systems

**Educational System**
- Classroom-based
- Teacher driven
- 1:1 Intervention
- Focus on academic
- 44 weeks of service
- Ancillary or Support Services Available (e.g., Speech or OT)
- Certified & credentialed staff required

**Adult System**
- Community-based
- Client driven
- Group supervision/support
- Focus on work & adaptive behavior
- 52 weeks of service
- Ancillary or Support Services Generally Not Available (e.g., Speech or OT)
- No requirement for certified of credentialed staff

**But what are “good outcomes” anyway?**

Any discussion of adult outcomes, however, needs to take into account the diversity of the individuals on the Autism Spectrum and much of our research in the area looks at individuals who are “high functioning”. In addition, positive adult outcomes are idiosyncratic at best and need to take into account the person-environment fit and whatever may, or may not, constitute their goals in life (e.g., Henninger & Taylor, 2013).

A few basic choices regarding valued and socially important adult outcomes?

- Community employment versus Day Habilitation Program
- Live at home versus live in a group home versus independent living.
- If live in group home, what size? 4 residents? 8 residents?
- Live in the country versus suburbs versus metropolitan area?
- Full-time supervision versus part-time supervision versus sporadic or no supervision.
- Kept protected from risk versus exposed to some level of risk versus full exposure to risk.
- Allowed full sexual expression within boundaries of law versus sexual expression moderated by various restrictions.

Just these simple values choices result in: 486 different combinations of what constitutes a valued outcome for an adult with ASD.

The Following is Rated “R” and is Considered Inappropriate for Younger Viewers.

Should adults with autism have access to internet porn? Which adults? Under internet what conditions? What types of porn?

But Remember...

- 70% of Men and 30% of Women watch porn.
- The average time spent on a porn site is 12 minutes.
- Porn sites have more visitors/month than Netflix, Amazon, Twitter, & YouTube combined.
- 60-70% of computers designated solely for work use will generally be found to contain porn files.

Source: http://www.huffingtonpost.com/2013/05/03/internet-porn-stats_n_3187682.html
According to the Resource Center for Adolescent Pregnancy Prevention (ReCAPP) and the American Sexual Health Association (ASHA)

- In 2013, 47% of high school students reported having sexual intercourse. Almost half (49.3%) of all 12th grade students reported being sexually active compared to almost 20% (19.6%) of 9th grade students.
- Many adolescents are engaging in sexual behaviors other than vaginal intercourse: nearly one-half have had oral sex, and just over one in 10 have had anal sex.
- Among sexually experienced teens, 73% of females and 58% of males reported that their first sexual experience had been with a steady partner or someone they had been cohabiting with, engaged to or married to, while 16% of females and 28% of males reported having first had sex with someone they had just met or who was just a friend.
- More than half of all people will have an STD/STI at some point in their lifetime.

For typical kids...

Porn has become a central mediator of young people’s sexual understanding and experience and a “go to” source for information on sex and sexuality in the absence of any formal sex education (Crabbe & Corlette, 2010).


The unavoidability of pornography?

Research (Mitchell, Finkelhor, & Wolak, 2003; Mitchell, Jones, Finkelhor & Wolak, 2014) indicates that approximately 25% of youth had unwanted exposure to sexual pictures on the Internet in the past year. The use of filtering and blocking software can result in modest reductions in unwanted exposure is far from fool proof.


So you have have:

- Normative data on porn viewership (i.e., typical behavior)
- Information regarding the ease with which sexual-related material can be accessed
- Research on sexual behavior among typical peers
- And info on the diversity of sexual expression.

Given that’s your decision? What are the implications of your decision for intervention?

It seems simple questions with simple answers are few and far between.

Unfortunately

Richards, et al (2006) noted historically, individuals with DD have been viewed as sexually deviant, prone to criminality, asexual, and problematic to society. Despite significant progress over the last 5 decades, the sexuality of individuals with DD is still grossly misunderstood by society. And although today the sexuality of individuals with DD is not entirely ignored, nor is sexual behavior universally punished, the perception of people with DD as perpetual children, irrespective of their age, still lingers with significant, negative consequences.

The EPIC School Policy on Sex Education

And that forms the basis for going forward in this talk

The need to be a generalist

If you work with young kids you get to be a specialist. Whether you're a special educator, speech pathologist, occupational therapist, or board certified behavior analyst, you get to be a specialist. When working with adolescents and young adults you don't get to be a specialist and, instead, need to be something of a generalist. In other words, you need a good working knowledge of ABA, Education Law, Labor Law, Mental Health concerns, medication side effects, sexuality, menstrual care, job development, job coaching, community-based instruction, generalized systems of communication, staff training, community training, and that's just to start.

Thankfully...

Applied behavior analysis has myriad applications far beyond ASD so my knowledge, expertise, and experience in the ABA/ASD field is pretty generalizable these other areas of need.

First, behavior analysts working with adults in the adult system generally don't have the luxury of being hyper-specialized.

While our literature base in ABA is deep, it application with adults with ASD has been fairly narrow.

The 7 Dimensions of ABA

- **Applied**: Deal with problems of social importance.
- **Behavioral**: Deal with measurable behavior or reports if they can be validated.
- **Analytic**: Require an objective demonstration that the procedures caused the effect.
- **Technological**: Are described well enough that they can be implemented by anyone with training and resources.
- **Conceptual Systems**: Arise from a specific and identifiable theoretical base rather than being a set of packages or tricks.
- **Effective**: Produce strong, socially important effects.
- **Generality**: Designed from the outset to operate in new environments and continue after the formal treatments have ended.

While all 7 dimensions are of critical importance, the most difficult ones (at least for me) seem to get the least discussion. These are:

- **Applied**: Deal with problems of social importance.
- **Effective**: Produce strong, socially important effects.
- **Generality**: Designed from the outset to operate in new environments and continue after the formal treatments have ended.

**Effective**: Produce strong, socially important effects.

Behavior analytic intervention in ASD has produced a string of strong, socially important effects. I am pretty sure we can all agree on that so we are good here.

- However, since Lovaas, (1987) and the subsequent research/practice in EIBI, what can we point to as being a strong, socially important behavior analytic “discovery” in autism intervention? 30 years seems a long-time between “discoveries” for such a young field.
- There have, of course, been a number of significant publications on innovative behavior analytic interventions since 1987 (e.g., Iwata, et al. 1994 on FBA) that have positively impacted the lives of individuals with ASD.


**Generality**: Designed [ ] to operate in new environments & continue after formal treatments have ended.

- Perhaps most bothersome here is the tendency to define a lack of generalization as begin an aspect of autism. While this may be true, I think it has become a convenient excuse.

**Applied**: Deals with problems of social importance

Effective autism intervention is certainly a problem of social importance. So we are good here. But if we drill down a bit the complexities start to emerge.

- I would, therefore, suggest that mere act of providing autism intervention is insufficient to fulfil this dimension. This has nothing to do with effectiveness of our interventions. This has to do with, all things considered, teaching the wrong skills effectively is no better than teaching the right skills poorly.

**We need to revisit context**

“Behavior analysts often emphasize the need to study the effects of ABA procedures in the context of typical practice settings (e.g., Johnston, 1996). However, reviews indicate that the large majority of our research focuses on interventions delivered by study personnel, usually in tightly controlled environments such as laboratories, specialized ABA classrooms, or distraction-free areas set up to provide one-to-one instruction [ ]. This discrepancy may reflect a dilemma that behavior analysts have had trouble resolving: We recognize that conducting studies in practice settings may require sacrificing some scientific rigor because the primary mission of such settings is to deliver services rather than conduct research (Johnston, 1996), yet we regard the quality of many studies in these settings as unacceptable (Johnston et al., 2006).” (Smith, 2013)

**We need to revisit context**

In their review and meta-analysis of functional living skills intervention, Neely, et al. (2016) concluded that:

- Planning for generalization and maintenance of skills can lead to larger effects in the sustained use of functional living skills.
- When using predetermined strategies, such as training in the natural setting or training to a preset criterion, individuals with ASD demonstrated large gains and maintained those gains over time.
- This indicates that practitioners CBI, when correctly implemented, appears to increase maintenance of taught functional living skills in this population.
If you want the citations
Johnston J. M. Distinguishing between applied research & practice. The Behavior Analyst.19, 35–47.

Mental Health Concerns Beginning to Grow in Impact in Adolescence
Children & adults who have a DD and a co-existing psychiatric disorder are one of the most underserved cohorts in the US. Beginning in adolescence, individuals with a developmental disability are two to four times more likely to have a psychiatric disorder than their Neurotypical peers. (Fletcher, et al., 2007)

Psychotropic Medication Use in ASD
Spencer, et al., (2013) examined rates of psychotropic use and polypharmacy among insured children with ASD from 2001 to 2009. The results indicated that among children with ASD, 64% had a filled prescription for at least 1 psychotropic medication, 35% had evidence of psychotropic polypharmacy (≥2 classes), and 15% used medications from ≥3 classes concurrently. Median length of polypharmacy was 346 days. The authors concluded that despite minimal evidence of the effectiveness of multidrug treatment of ASD, psychotropic medications are commonly used, singly and in combination, for ASD and its co-occurring conditions.

But back to the complexity of real life

Anxiety Disorders
Vasa, et al (2013) examined age-related differences in the prevalence and anxiety in a large sample of children & adolescents with ASD in the US and Canada. Findings showed that the prevalence of anxiety in each age group exceeded the prevalence of anxiety in the general population. Adolescents and school age children had the highest prevalence of clinical (40%) and subclinical anxiety (26%), respectively.

And another in access to adequate, effective medical care
Access to Adequate Healthcare

- Croen, (2015), reported that adults with autism had significantly increased rates of all major psychiatric disorders and nearly all medical conditions were significantly more common in adults with autism, including immune conditions, GI and sleep disorders, seizure, obesity, dyslipidemia, hypertension, and diabetes. Rarer conditions, such as stroke and Parkinson’s disease, were also significantly more common among adults with autism.
- Cheak-Zamora, et al. (2013) found that youth with ASD experience disparities in access to Healthcare Transition Services and youth with comorbid conditions are at greatest risk for poor access to Healthcare Transition Services.
- "This is an impending health care or community care crisis. The services that are available vary from state to state, but often the resources just aren’t there." Dr. Joseph Cubells, Director of Medical and Adult Services at the Emory Autism Center

Access to Adequate Healthcare

- Bruder, et al (2012) noted that while there is a small cohort of physicians in Connecticut that provide medical care for adults with ASD, the majority of those who do have adult ASD patients actually serve very few.
- Using the Nationwide Emergency Department Sample (2006–2011), Vohra and colleagues (2017) reported the mean total of Emergency Room changes for adults with ASD were 2.3 times higher than adults without ASD.
- From their review of the a nationally diverse, clinically rich, private insurance claims database, Nathenson & Zablotsky; (2017) reported that the proportion of youths with ASD who received services declined with age in each setting except the ED. Service utilization declined faster among youths with co-occurring intellectual disability.

Adaptive Behavior: Real Skills Used in the Real World

“Adaptive Behavior is defined as those skills or abilities that enable the individual to meet standards of personal independence and that would be expected of his or her age and social group. Adaptive behavior also refers to the typical performance of individuals without disabilities in meeting environmental expectations. Adaptive behavior changes according to a person’s age, cultural expectations, and environmental demands.” (Heward, 2005).

Matson, Rivet, Fodstad, Dempsey, & Boisjoli, (2009) evaluated 337 adults using the Vineland Adaptive Behavior Scale to assess the differential impact of having 1) an Intellectual Disability (ID), 2) an ID plus ASD, or 3) an ID, ASD, and an Axis I mental health diagnosis. Adaptive skills were greatest for the ID group followed by the ID plus ASD, and ID and ASD plus psychopathology. Thus, the greater the complexity of diagnoses, the greater the skills deficits observed, particularly where psychopathology was concerned.

My Favorite, and simplest, Adaptive Behavior Assessment

What you do EVERY DAY matters more than what you do ONCE IN A WHILE.

Chores (ADLs) that typical children can do.

<table>
<thead>
<tr>
<th>AGE</th>
<th>CHORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-4 year olds</td>
<td>Help dust, Put napkins on table, Put laundry in hamper, Help feed pet</td>
</tr>
<tr>
<td>4-7 year olds</td>
<td>Set (or help set) the table, Put away toys, Help make bed, Help put dishes in dishwasher, Help clear table, Help put away groceries, Water the garden</td>
</tr>
<tr>
<td>8-10 year olds</td>
<td>Make bed, Set &amp; clear table, Dust, Vacuum, Help wash car, Help wash dishes, Take out the trash</td>
</tr>
<tr>
<td>11 year olds and older</td>
<td>Above plus clean room, Mow lawn, Feed pets, Start doing own laundry, Make small meals, Shovel snow, Help with yard work, Empty and load dishwasher, etc.</td>
</tr>
</tbody>
</table>

Social Skills Exist Because of Their Function

Social skills are mediated by their outcome in that they are used to acquire desirables and avoid negatives while navigating the environment and manipulating others in that environment.

But rather logarithmic in nature

What is a logarithm?

A logarithm is the power to which a number must be raised in order to get some other number.

If \( y = b^x \), then \( \log_b{y} = x \).

For example, the base ten logarithm of 100 is 2, because ten raised to the power of two is 100:

\[ 100 = 10^2 \text{ because } \log_{10}{100} = 2 \]
In other words...

"A greeting is a social skill that is thought to be simple. However, further analysis shows this skill, which most take for granted, to be extremely complex. How a child greets a friend in the classroom differs from the type of greeting that would be used if the two met at the local mall. The greeting used the first time the child sees a friend differs from the greeting exchanged when they see each other 30 minutes later. Further, words and actions for greetings differ, depending on whether the child is greeting a teacher or a peer... [G]reetings are complex, as are most social skills."

Myles & Simpson (2001)

All of which leads me to greatest complexity:

Quality of Life is Not a New Concept

Not life, but good life, is to be chiefly valued.

Socrates
(469 BC - 399 BC)

QOL as a human right

All persons enjoy the “right to be left alone,... the privilege of an individual to plan his own affairs,... to shape his own life as he thinks best, do what he pleases, go where he pleases,... the freedom to walk, stroll or loaf.”

Supreme Court Justice William O. Douglas (1973)

Top 10 Places to Live for QOL

1. Madison, Wisconsin.
2. Lincoln, Nebraska
3. Minneapolis, Minnesota
4. St. Paul, Minnesota
5. Omaha, Nebraska
7. Lexington, Kentucky
8. Lubbock, Texas
9. Fort Wayne, Indiana
10. Fremont, California

But I live in Weehawken NJ
(Yes, this is a shot of daybreak over NYC from just outside my apartment)
The point is, QOL is a Complex Construct

A useful, and somewhat measurable, definition of QoL

Quality of life (QOL) is a term used to describe a **temporal condition of personal satisfaction** with such core life conditions as physical well-being, emotional well-being, interpersonal relations, social inclusion, personal growth, material well being, self-determination, and individual rights. (Wehmeyer & Schalock, 2001)

But in ASD, while the concept of quality of life has been used for over 30 years in the field of intellectual disabilities, the factors contributing to quality of life of persons with ASD have received relatively little attention (Renty & Roeyers, 2006) in the literature and in practice.

Much of the research on QOL and ASD has focused on a limited number of aspects of adult life (e.g., employment) and primarily on quantitative aspects of these few domains (e.g., employed v. employment satisfaction). QOL, however, is much more complex state of being (Van Heijst & Geurts, 2015).

Van Heijst & Guerts, (2015) recently completed a meta-analysis on the topic of QOL and adults with ASD. An extensive literature review identified a total of 10 peer reviewed studies published on 2004-2012. The results indicated that the quality of life is significantly lower for people with autism when compared to their typical peers. Age, IQ and symptom severity did not predict quality of life in this sample. Across the lifespan, people with autism experience a much lower quality of life compared to people without autism.

However...

Parsons (2015) conducted an online survey designed to solicit the views of adults with ASD about current life satisfaction. Fifty-five respondents, most of whom attended mainstream schools and were diagnosed later in life, completed the survey. Respondents were least satisfied with their current employment situation and most satisfied with personal relationships. There was substantial individual variation in responses demonstrating the importance of respecting personal views, circumstances and aspirations. This is significant as little is known about the actual views of adults with ASD on QOL and that, in general, "good outcomes" in adult life are often judged according to normative assumptions of quality.
For me, it all comes down to having choice in your life, and to access your choices, and

The ability to exercise personal control over important things, and

“[] happiness among people with profound multiple disabilities can be defined, reliably observed, and systematically increased” supporting the fact that “the contributions of behavior analysis for enhancing the quality of life among people with profound and multiple disabilities may be increased significantly.” (Green & Reid, 1996)

So maybe, on a very basic level, Quality of Life comes down to

- **Choice** to be employed, in what job in what field when the opportunity is available.
- **Opportunity** to try different things in order to discover individual likes, dislikes, preferences, interests.
- **Control**, to the extent possible, over events or actions that impact your life
- The chance to be Happy because you have choice, opportunity, and control.

Some Final Thoughts
For many adults with ASD the idea of “placement” has become substituted for any semblance of QoL.

Fear continues to guide many life-altering decisions made for individuals with ASD often leaving them outside their community.

This despite the fact that the more included you are in your community the, arguably, safer you are.

If you’ve never read this article, it’s well worth 30 minutes of your time.

We Need to Embrace and Push Technology to Work for Us

Technology, whether low tech or high tech, is part of the world as we know and is changing the lives of individuals with ASD. From assistive communication technology on an I-Pad, to GPS tracking, to Apple Pay, to self-driving cars, and to instruction via virtual reality we really have only scratched the surface in terms of technology’s potential.
Accept that life is not perfect

No one is 90% accurate with every skill all the time in every context

- For example, a recent study found that 15% of men and 7% of women didn’t wash their hands at a public restroom. When they did wash their hands, only 50% of men used soap, compared to 78% of women. Further, only 5% of people who washed their hands scrubbed long enough to kill germs that can cause infections.
- A recent study found to only about 20% of Americans actually balance their checkbook yet this skill remains a staple of “functional” transition programming.
- In a recent study on casual sex during spring break, researchers found that 15% of men and 13% of women had sex with someone they just met. Further 77% of college-age women and 83% of men reported having had casual sex at least once.

Recognize, Control For, but Accept Reasonable Risk

You only live once and your not coming back...... so take the risk, what is the worst that can happen

What’s the Worst Best That Could Happen?
Safety Skills

Physical Safety
Simple Discrim Skills
- Hot/Cold, Wet/Dry
- Light/Dark
- Sharp/Dull, Stop/Go
- Quiet/Loud, ETC

Complex Discrim Skills
- Near/Far, Many/Few
- Fast/Slow, High/Low
- ETC

Multiple Discrim Skills
- Cold/Wet/Red
- Cold/Dry/Red

Situational Discrim Skills
- Where, When Who, What, How
- Stranger/Mall vs Stranger/Home,
  Fast Car/My Street, Fast Car/Cross Street

Social Safety

Emotional Safety
Response to Failure in either the physical or social safety domain.
Intervention may take form of IST, CBT, or systematic desensitizing.

Accurate?
- Always – Sometimes – Rarely – Never

Error-based learning.
- “Learning from errors is one of the basic principles of motor skill acquisition” (Seidler, Kwak, Fling, & Bernard, 2013, p.1)
- Medical training must at some point use live patients to hone the skills of health professionals. But there is also an obligation to provide optimal treatment and to ensure patients’ safety and well-being. Balancing these 2 needs represents a fundamental ethical tension in medical education. Simulation-based learning can help mitigate this tension by developing health professionals’ knowledge, skills, and attitudes while protecting patients from unnecessary risk. Simulation-based training has been institutionalized in other high-hazard professions, such as aviation, nuclear power, and the military, to maximize training safety and minimize risk (Ziv, et al., 2006).

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The EPIC School Policy on Instructional Risk

When we have interventions that are evidence-based, they need to be used.

Video Modeling: An EBP
- Video modeling interventions involve having an individual with ASD watch a video of an adult, peer, or him/herself perform a behavior correctly, in hopes that the individual with ASD will begin to spontaneously perform the observed behavior after viewing it on video.
- Video modeling has been used to teach a variety of social, educational, adaptive, and vocational tasks to individuals with autism (Bellini and Akullian 2007) although only one study (Nikopoulos and Keenan, 2003) has targeted social skills in older individuals


Social Stories or Scripts: Not so much
Social Stories, popularized by Carol Gray, consist of brief stories or scripts describing a particular social, behavioral, or problem solving skill. Though popular, the research into the effectiveness of Social Stories is, at best, mixed. One possible explanation is that there may be two different groups of individuals (i.e., responders v. non-responders) but, beyond a certain level of language comprehension, the characteristics of each group are undefined.
Peer Mediated Social Interventions: Possibly EBP

A small number of studies have found that peer-mediated interventions, can be effective at increasing social interactions of individuals with ASD (Chan et al., 2009). Peer mediated interventions are those in which typically developing peers are taught strategies for interacting with individuals with ASD. Peer-mediated strategies are meant to capitalize on the existing social skills of typical peers and to serve as models of appropriate social behavior. (Chan et al., 2009).


Social Skill Groups: Not so much

- Social Skill Groups, while commonly used with high verbal individuals, lack an adequate research based. Among the myriad questions are what constitutes a social skills group, what curriculum is used, what social behaviors are targeted, how frequently should sessions be run and, how many sessions are needed to produce behavior change.

This was a very brief overview and, as such, I didn’t even touch on:
- Employment
- Leisure & Recreation
- Self Advocacy
- Sexuality Education
- Protection from Abuse & Neglect
- Housing
- Middle- to Older-Age Concerns
- Relationships
- Grief
- Challenging behavior and PBS
- Social inclusion (process and outcome)
- And so much more of what constitutes a desirable, positive quality of life on a case by case basis

So to wrap this up...

At EPIC, Students Need to Graduate

- Employed a minimum of 20 hours
- With functional system of communication
- Independent in basic self-care,
- Able to follow a schedule and remain engaged a minimum of 45 minutes
- With a functional leisure repertoire, and
- As part of the community they live and work.

But I am not entirely sure how I am going to do this but If figure there has to be a first time for everything.
Don’t dream it. Be it!

Billy has 32 pieces of bacon. He eats 28. What does he have now? Happiness. Billy has happiness.

A failure is not always a mistake, it may simply be the best one can do under the circumstances. The real mistake is to stop trying.

B.F. Skinner
1904 - 1990