3 Treatment Models

ABA treatment programs for ASD incorporate findings from hundreds of applied studies focused on understanding and treating ASD published in peer-reviewed journals over a 50-year span. Treatment may vary in terms of intensity and duration, the complexity and range of treatment goals, and the extent of direct treatment provided. Many variables, including the number, complexity, and intensity of behavioral targets and the client's own response to treatment help determine which model is most appropriate. Although existing on a continuum, these differences can be generally categorized as one of two treatment models: Focused or Comprehensive ABA Treatment.[3]

1| Focused ABA Treatment

Service Description

Focused ABA refers to treatment provided directly to the client for a limited number of behavioral targets. It is not restricted by age, cognitive level, or co-occurring conditions.

Focused ABA treatment may involve increasing socially appropriate behavior (for example, increasing social initiations) or reducing problem behavior (for example, aggression) as the primary target. Even when reduction of problem behavior is the primary goal, it is critical to also target increases in appropriate alternative behavior, because the absence of appropriate behavior is often the precursor to serious behavior disorders. Therefore, individuals who need to acquire skills (for example, communication, tolerating change in environments and activities, self-help, social skills) are also appropriate for Focused ABA.

Focused ABA treatment may involve increasing socially appropriate behavior … or reducing problem behavior.

Focused ABA plans are appropriate for individuals who (a) need treatment only for a limited number of key functional skills or (b) have such acute problem behavior that its treatment should be the priority.

Examples of key functional skills include, but are not limited to, establishing instruction-following, social communication skills, compliance with medical and dental procedures, sleep hygiene, self-care skills, safety skills, and independent leisure skills (for example, appropriate participation in family and community activities). Examples of severe problem behaviors requiring focused intervention include, but are not limited to, self-injury, aggression, threats, pica, elopement, feeding disorders, stereotypic motor or vocal behavior, property destruction, noncompliance and disruptive behavior, or dysfunctional social behavior.

When prioritizing the order in which to address multiple treatment targets, the following should be considered:

- **Behavior that threatens the health or safety of the client or others or that constitute a barrier to quality of life** (for example, severe aggression, self-injury, property destruction, or noncompliance);
- **Absence of developmentally appropriate adaptive, social, or functional skills that are fundamental to maintain health, social inclusion, and increased independence** (for example, toileting, dressing, feeding, and compliance with medical procedures).

When the focus of treatment involves increasing socially appropriate behavior, treatment may be delivered in either an individual or small-group format. When conducted in a small group, typically developing peers or individuals with similar diagnoses may participate in the session. Members of the behavior-analytic team may guide clients through the rehearsal and practice of behavioral targets with each other. As is the case for all treatments, programming for generalization of skills outside the session is critical.

When the focus of treatment involves the reduction of severe problem behavior, the Behavior Analyst will determine which situations are most likely to precipitate problem behavior and, based on this information, begin to identify its potential purpose (or "function"). This may require conducting a functional analysis procedure to empirically demonstrate the function of the problem behavior. The results enable the Behavior Analyst to develop the most effective treatment protocol. When the function of the problem behavior is identified, the Behavior Analyst will design a treatment plan that alters the environment to reduce the motivation for problem behavior and/or establish a new and more appropriate behavior that serves the same function and therefore "replaces" the problem behavior.

In some cases, individuals with ASD display co-occurring severe destructive behavior disorders that require focused treatment in more intensive settings, such as specialized intensive-outpatient, day-treatment, residential, or inpatient programs. In these cases, these behavior disorders are given separate and distinct diagnoses (for example, Stereotypic Movement Disorder with severe self-injurious behavior). The ABA services delivered in these settings typically require higher staff-to-client ratios (for example, 2 to 3 staff for each client) and close on-site direction from the Behavior Analyst. In addition, such treatment programs often have specialized treatment environments (for example, treatment rooms designed for observation and to keep the client and the staff as safe as possible).

2| Comprehensive ABA Treatment

Service Description

Comprehensive ABA refers to treatment of the multiple affected developmental domains, such as cognitive, communicative, social, emotional, and adaptive functioning. Maladaptive behaviors, such as noncompliance, tantrums, and stereotypy are also typically the focus of treatment. Although there are different types of comprehensive treatment, one example is early intensive behavioral intervention where the overarching goal is to close the gap between the client's level of functioning and that of typically developing peers. These programs tend to range from 30-40 hours of treatment per week (plus direct and indirect supervision and caregiver training). Initially, this treatment model typically involves 1:1 staffing and gradually includes small-group formats as appropriate. Comprehensive treatment may also be appropriate for older individuals diagnosed with ASD, particularly if they engage in severe or dangerous behaviors across environments.

Initially, treatment is typically provided in structured therapy sessions, which are integrated with more naturalistic methods as appropriate. As the client progresses and meets established criteria for participation in larger or different settings, treatment in those settings and in the larger community should be provided. Training family members and other caregivers to manage problem behavior and to interact with the individual with ASD in a therapeutic manner is a critical component of this treatment model.

Typical Program Components

Treatment components should generally be drawn from the following areas (ordered alphabetically):

- adaptive and self-care skills
- attending and social referencing
- cognitive functioning
- community participation
- coping and tolerance skills
- emotional development
- family relationships
- language and communication
- play and leisure skills
- pre-academic skills
- reduction of interfering or inappropriate behaviors
- safety skills
- self-advocacy and independence
- self-management
- social relationships
- vocational skills

For information on treatment intensity and duration for various Focused and Comprehensive Treatments, see Section 4 (Service Authorization and Dosage).

4 Variations Within These Models

Treatment programs within any of these models vary along several programmatic dimensions, including the degree to which they are primarily provider- or client-directed (sometimes described as "structured vs. naturalistic"). Other variations include the extent to which peers or parents are involved in the delivery of treatment. Finally, some differ in terms of the degree to which they are "branded" and available commercially.

Decisions about how these various dimensions are implemented within individual treatment plans must reflect many variables, including the research base, the age of the client, specific aspects of the target behaviors, the client's rate of progress, demonstration of prerequisite skills, and resources required to support implementation of the treatment plan across settings.

5 ABA Procedures Employed In These Models

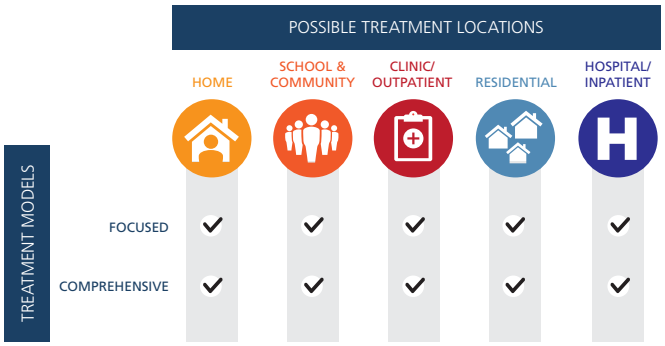
A large number of ABA procedures are routinely employed within the models previously described. They differ from one another in their complexity, specificity, and the extent to which they were designed primarily for use with individuals diagnosed with ASD. All are based on the principles of ABA and are employed with flexibility determined by the individual's specific treatment plan and response to treatment. If one ABA procedure or combination of ABA procedures is not producing the desired outcomes, a different one may be systematically implemented and evaluated for its effectiveness.

These procedures include different types of reinforcement and schedules of reinforcement, differential reinforcement, shaping, chaining, behavioral momentum, prompting and fading, behavioral skills training, extinction, functional communication training, discrete-trial teaching, incidental teaching, self-management, functional assessment, preference assessments, activity schedules, generalization and maintenance procedures, among many others (see the BACB Fourth Edition Task List). The field of behavior analysis is constantly developing and evaluating applied behavior-change procedures.

6 Locations Where Treatment is Delivered

The standard of care provides for treatment to be delivered consistently in multiple settings to promote generalization and maintenance of therapeutic benefits. No ABA model is specific to a particular location and all may be delivered in a variety of settings, including residential treatment facilities, inpatient and outpatient programs, homes, schools, transportation, and places in the community. Treatment across settings with multiple adults, siblings, and/or typically developing peers, under the supervision of a Behavior Analyst, supports generalization and maintenance of treatment gains. It should be noted that treatment might occur in multiple settings (for example, home, community, and transportation) on the same day. Treatment should not be denied or withheld because a caregiver cannot be at the treatment location consistently.

To ensure continuity of care, sufficient ABA treatment and consultation should be delivered in subsequent educational and therapeutic settings (for example, residence to school, hospital to home) to successfully support and transition individuals.



7 Client Age

Treatment should be based on the clinical needs of the individual and not constrained by age. Consistent ABA treatment should be provided as soon as possible after diagnosis, and in some cases services are warranted prior to diagnosis. There is evidence that the earlier treatment begins, the greater the likelihood of positive long-term outcomes. Additionally, ABA is effective across the life span. Research has not established an age limit beyond which ABA is ineffective.

> *There is evidence that the earlier treatment begins, the greater the likelihood of positive long-term outcomes.*

8 Combining ABA With Other Forms Of Treatment

Findings from several studies show that an eclectic model, where ABA is combined with non-evidence-based treatment, is less effective than ABA alone. Therefore, treatment plans that combine ABA with additional procedures that lack scientific evidence as established by peer-reviewed publications should be considered eclectic and do not constitute ABA treatment.