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The Evidence for the Community Standard of Care of Applied Behavior Analysis (ABA) for Adults with Autism, Behavior Disorders, and Developmental Disabilities

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There is extensive research in the field of Applied Behavior Analysis (ABA) that shows the effectiveness of focused treatment of behavior disorders with persons who are older than age 18 and who suffer from developmental disabilities including autism. As a result ABA is a community standard of care for adults, particularly in residential treatment and vocational supports.

In the research listed here, over 1,800 persons older than age 18 who were documented as receiving effective ABA treatment.

As a result, *especially for persons in adulthood*, ABA is clearly a widely established component of the community standard of care. Many of these studies include young adults; and many more specifically have studied the results of ABA with the adult population. Many of the following studies were published in the 1980's and 1990's, which underscores the long and substantial role of ABA treatment as part of the community standard of care for adults who suffer from autism and other developmental disorders.

An important area of concern is the CDC's conclusion that economically disadvantaged persons are much less likely to be diagnosed and served optimally in childhood (www.cdc.gov/childrensmentalhealth/access.html). The result is that any age limit in treatment authorization is likely to disproportionately impact those adults who come from disadvantaged backgrounds.

This review is broken into several sections:

- I. Peer reviews and/or meta-analyses of ABA treatment that included persons over the age of twenty-one.
- II. Studies of the relationship of socioeconomic status with age of autism diagnosis.
- III. The conclusions of independent review panels on evidence-based ABA practices including adults.
- IV. An additional 330 studies and reports that extend the evidence base for ABA as part of the community standard of care for the treatment of persons who suffer from autism who are older than age 18.

I. The following studies reported peer reviews and/or meta-analyses of ABA treatment that included persons over the age of twenty-one.

Asmus, Ringdahl et al., in 2004, reported on 138 persons aging from one to over 21, who were evaluated and treated for aberrant behaviors such as aggression, self-injury, and destruction on a short-term inpatient unit:

“Aberrant behavior was reduced by 90% for the majority (66%) of the participants in an average time frame of 10 days. (page 300).

“Reduction of 20% or more was seen for all but 4 of the 138 participants.” (page 300).

Asmus, J.M., Ringdahl, J.E., Sellers, J.A., Call, N.A., Andelman, M.S. & Wacker, D.P. (2004). Use of A Short-Term Inpatient Model To Evaluate Aberrant Behavior: Outcome Data Summaries From 1996 To 2001. Journal of Applied Behavior Analysis. 37, 283-304.

Campbell, in 2003, reported a meta-analysis of 117 published studies of behavioral interventions for the problem behaviors of 181 persons with autism, who ranged in age from two to 31 years of age. The problem behaviors included stereotypic behavior, self-injurious behavior, aggression and destruction:

“behavioral treatments were found to be significantly effective in reducing problem behavior in persons with autism. (page 133).

“Treatment was equally effective regardless of problem behavior and type of technique used. (page 133).

“The most salient clinical implication is that behavioral treatments are more effective when preceded by a functional assessment.” (page 134).

Campbell, J.M. (2003). Efficacy of behavioral interventions for reducing problem behavior in persons with autism: a quantitative synthesis of single-subject research. Research in Developmental Disabilities, 24, 120-138.

Hagopian, Rooker, Jessel, & DeLeon, in 2013, reported a case-series analysis of functional analyses of the behavior of 176 persons who were between the ages of three and 39 years old, and who had been admitted to an inpatient unit for severe problem behavior:

“a function was identified in 86.9% of the 176 cases and in 93.3% of the 161 cases for which the FA, if necessary, was modified up to 2 times. (page 95).

“These results indicate that multiple control was the most common finding, followed by social-positive reinforcement.” (page 95).

Hagopian, L.P., Rooker, G.W., Jessel, J., & DeLeon, I.G. (2013). Initial Functional Analysis Outcomes and Modifications in Pursuit of Differentiation: A Summary of 176 Inpatient Cases. Journal of Applied Behavior Analysis, 46, 88-100.

Hagopian, Rooker, & Rolider. In 2011, reviewed the treatment of pica in 50 persons from the ages of two to over 21. Using APA criteria for empirically supported treatments, a total of 34 treatment studies were identified:

“these behavioral approaches are highly effective in reducing pica – as most studies identified reduced pica by more than 90% relative to baseline. (page 2118).

“there are more than a sufficient number of high-quality studies in the literature to characterize behavioral treatment as well established empirically supported treatments. (page 2118).

“Treatments combining reinforcement and response reduction procedures also exceed criteria to be designated as well established.” (page 2118).

Hagopian, L.P., Rooker, G.W., & Rolider, N.U. (2011). Identifying empirically supported treatments for pica in individuals with intellectual disabilities. Research in Developmental Disabilities, 32, 2114–2120.

Hanley, Iwata, and McCord, in 2003, reported on 277 studies, which included 198 adults older than 18, who received functional analyses of problem behaviors:

“96 percent were able to yield an analysis of the controlling variables of the problem behavior. (pages 166-167).

“The specific functional analysis of individual problem behaviors is crucial to the successful intervention with those behaviors. (pages 166-167).

“Large proportions of differentiated functional analyses showed behavioral maintenance through social-negative (34.2%) and social-positive reinforcement (35.4%). More specifically, 25.3% showed maintenance via attention and 10.1% via access to tangible items. Automatic reinforcement was implicated in 15.8% of cases.” (pages 166-167).

Hanley, G., Iwata, B.A., & McCord, B.E. (2003). Functional analysis of problem behavior: A review. Journal of Applied Behavior Analysis, 36, 147-185.

Iwata and colleagues, in 1994, reported on the effective treatment of self-injurious behavior that included 74 persons who were 21 and older:

“The function of the self-injurious behavior could be identified in 95% of the persons, and in 100% of those cases an effective treatment could then be prescribed. (page 233).

“Across all categories of intervention, restraint fading was the most effective, but its 100% success rate is misleading because it was always implemented in conjunction with another procedure. (page 233).
 “As single interventions, EXT (escape) had the highest success rate (93.5%); sensory integration and naltrexone had the lowest (0%). (page 233).
 “Results of the present study, in which single-subject designs were used to examine the functional properties of SIB in 152 persons, indicated that social reinforcement was a determinant of SIB in over two thirds of the sample, whereas nonsocial (automatic) consequences seemed to account for about one fourth of the cases.” (page 234).

Iwata, B.A., Pace, G.M., et al. (1994). The functions of self-injurious behavior: An experimental-epidemiological analysis. Journal of Applied Behavior Analysis, 27, 215-240.

Jennett and Hagopian, in 2008, reported on 28 persons aged seven to above 21, who received a variety of forms of behavior therapy treatments for phobic avoidance. These were in 12 studies, which demonstrated treatment efficacy through the use of good experimental design:

“there is sufficient empirical support to characterize behavioral treatment as a well-established treatment for phobic avoidance displayed by persons with intellectual disabilities. (page 158).
 “All of the studies described that had good experimental designs and were shown to be efficacious included some form of live exposure to the feared stimulus plus reinforcement for appropriate behaviors (e.g., approach or absence of avoidance), suggesting that these are important components of treatment.” (page 158).

Jennett, H.K. & Hagopian, L.P. (2010). Identifying Empirically Supported Treatments for Phobic Avoidance in Individuals With Intellectual Disabilities. Behavior Therapy, 39, 151-161.

Lang, et al. in 2010, reported on nine studies, which involved 110 persons, aged nine to 23, who received a variety of forms of behavior therapy for anxiety:

“Within each reviewed study, at least one dependent variable suggested a reduction in anxiety following implementation of CBT.” (page 60).
 “CBT has been modified for individuals with ASD by adding intervention components typically associated with applied behaviour analysis (e.g. systematic prompting and differential reinforcement). Future research involving a component analysis could potentially elucidate the mechanisms by which CBT reduces anxiety in individuals with ASD, ultimately leading to more efficient or effective interventions.” (page 53).

Lang, R., Regester, A., Lauderdale, S., Ashbaugh, K., & Haring, A. (2010). Treatment of anxiety in autism spectrum disorders using cognitive behaviour therapy: a systematic review. Developmental Neurorehabilitation, 13, 53-63.

Lang, et al. in 2009, reported on ten studies which involved 53 persons from the ages of three to above 21, who received a variety of ABA interventions for the treatment of dangerous elopement. However, in this one review, none of the reviewed treatments were found to qualify as “well established” evidence-based practice:

“elopement may often be maintained by operant contingencies and reduced by function-based interventions. (page 679).
 “The studies with the most conclusive evidence ostensibly suggest a two-step process; practitioners should (a) assess elopement to identify its operant function, and (b) implement a function-based intervention” (page 679).

Lang, R., Rispoli, M., et al. (2009). Treatment of elopement in individuals with developmental disabilities: A systematic review. Research in Developmental Disabilities, 30, 670-681.

Reichow and Volkmar, in 2010, reported on 31 studies of 327 persons, from the ages of six to over 21, who benefited from ABA social skills training:

“Within the last 8 years, 66 studies with strong or acceptable methodological rigor have been conducted and published. These studies have been conducted using over 500 participants, and have evaluated interventions with different delivery agents, methods, target skills, and settings. (page 161).
 “Collectively, the results of this synthesis show there is much supporting evidence for the treatment of social deficits in autism.” (page 161).

Reichow, B. & Volkmar, F.R. (2010). *Social Skills Interventions for Individuals with Autism: Evaluation for Evidence-Based Practices within a Best Evidence Synthesis Framework. Journal of Autism and Developmental Disorders. 40, 149-166.*

II. Studies of the relationship of socioeconomic status with age of autism diagnosis.

It is crucial to eliminate arbitrary age caps in coverage, because they will inevitably impair the disadvantaged in disproportionate numbers. In a 2018 CDC study of factors associated with age of diagnosis of autism, the CDC reported the following:

- The average age of diagnosis of autism is 5.7 years.
- The average age of diagnosis in children with IQs over 70 is 6.6 years.
- The average age of diagnosis in children whose mothers were teenagers at birth is 6.6 years.
- The average age of diagnosis in children whose mothers had less than 12 years of school is 6.3 years.
- 27% of the children with autism had not been diagnosed by the age of 8.

This and other studies listed below suggest that economically disadvantaged children are unlikely to be diagnosed with autism until after the optimal early intervention window. What was also consistently found are that less minority children are ever diagnosed with autism. This suggests that the age data is severely confounded by the lack of reliable evaluation services for minority children. One study found that rural children are also diagnosed later (at the average age of 8.1 years).

Therefore age-caps are likely to discriminate against disadvantaged children. Therefore it is imperative that society cover the costs of appropriate ongoing treatment for those persons who were not availed of timely early intervention.

References on the adverse impact of age caps on disadvantaged populations.

- Baio J, Wiggins L, Christensen DL, et al. (2018). Prevalence of Autism Spectrum Disorder Among Children Aged 8 Years — Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2014. *Morbidity and Mortality Weekly Report Surveillance Summary. 67*(No. SS-6):1–23. DOI: <http://dx.doi.org/10.15585/mmwr.ss6706a1external icon>.
- Jarbrink, K., McCrone, P., Fombonne, E., Zanden, H., & Knapp, M. (2007). Cost-impact of young adults with high-functioning autistic spectrum disorder. *Research in Developmental Disabilities. 28, 94-104.*
- Mandell, D.S., et al. (2009). Racial and ethnic disparities in the identification of children with autism spectrum disorders. *American Journal of Public Health, 99, 493-498.*
- Mandell, D.S., Listerud, J., Levy, S.E., & Pinto-Martin, J.A. (2002). Race differences in the age at diagnosis among Medicaid-eligible children with autism. *Journal of the American Academy of Child and Adolescent Psychiatry, 41, 1447-1453.*
- Mandell, D.S., Novak, M.M., & Zubritsky, C.D. (2005). Factors associated with age of diagnosis among children with autism spectrum disorders. *Pediatrics. 116, 1480-1486.*
- Riglin L, Wootton RE, Thapar AK, et al. (2021). Variable emergence of autism spectrum disorder symptoms from childhood to early adulthood. *Am J Psychiatry, 178:752–760*
- Shattuck, P.T., et. al. (2009). Timing of Identification Among Children With an Autism Spectrum Disorder: Findings From a Population-Based Surveillance Study. *Journal of the American Academy of Child and Adolescent Psychiatry, 48, 474-483*

III. The conclusions of independent review panels on evidence-based ABA practices including adults.

The US Department of Education commissioned a review of the evidence supporting focused ABA intervention practices. The Autism Evidence-Based Practice Review Group of the **Frank Porter Graham Child Development Institute** set about to describe a process for the identification of evidence-based practices (EBPs) and also to delineate practices that have sufficient empirical support to be termed evidence-based. After reviewing 29,106 published articles, they found 1,090 that met their criteria, resulting in the identification of 27 evidence-based practices that consisted of focused interventions:

“that are fundamental applied behavior analysis techniques (e.g., reinforcement, extinction, prompting), assessment and analytic techniques that are the basis for intervention (e.g., functional behavior assessment, task

analysis), and combinations of primarily behavioral practices used in a routine and systematic way that fit together as a replicable procedure (e.g., functional communication training, pivotal response training).” (p. 19).

“Fifteen of the EBPs have over 10 studies providing empirical support for the practice, and among those, the foundational applied behavior analysis techniques (e.g., prompting and reinforcement) have the most support. Antecedent-based interventions, differential reinforcement, and video modeling also have substantial support with over 25 studies supporting their efficacy. The number and variety of these replications speak to the relative strength of these EBPs.” (p. 29)

“The identification of focused intervention practices that have substantial evidence of efficacy provides the basis for designing comprehensive evidence-supported programs for children and youth with ASD... Developers of some comprehensive treatment models, such as the Lovaas Model and the Early Start Denver Model, have conducted randomized efficacy studies that provide empirical support for their program models, which would qualify them as evidence-based programs.” (p. 32)

Wong, C., Odom, S. L., Hume, K. Cox, A. W., Fettig, A., Kucharczyk, S., ... Schultz, T. R. (2014). *Evidence-based practices for children, youth, and young adults with Autism Spectrum Disorder*. Chapel Hill: The University of North Carolina, Frank Porter Graham Child Development Institute, Autism Evidence-Based Practice Review Group. Available at: autismpdc.fpg.unc.edu/sites/autismpdc.fpg.unc.edu/files/2014-EBP-Report.pdf

Steinbrenner, J. R., Hume, K., Odom, S. L., Morin, K. L., Nowell, S. W., Tomaszewski, B., Szendrey, S., McIntyre, N. S., Yücesoy-Özkan, S., & Savage, M. N. (2020). *Evidence-based practices for children, youth, and young adults with Autism*. The University of North Carolina at Chapel Hill, Frank Porter Graham Child Development Institute, National Clearinghouse on Autism Evidence and Practice Review Team.

In 2015, the **National Center for Autism** identified evidence-based ABA practices. The Center found the following behavioral interventions that had their own unique established level of evidence: Behavioral Interventions, Cognitive Behavioral Intervention Package, Language Training (Production), Modeling, Natural Teaching Strategies, Parent Training, Peer Training Package, Pivotal Response Training, Schedules, Scripting, Self-Management, Social Skills Package, and Story-based Intervention. Each of these interventions had to be supported by studies that met the criteria of the Scientific Merit Rating Scale (SMRS) and the Strength of Evidence Classification System, as follows:

“The SMRS involves five critical dimensions of experimental rigor that can be applied to determine the extent to which interventions are effective. They are: {a} research design, {b} measurement of the dependent variable, {c} measurement of the independent variable or procedural fidelity, {d} participant ascertainment, and {e} generalization and maintenance.” (p. 22)

“Sufficient evidence is available to confidently determine that an intervention produces favorable outcomes for individuals on the autism spectrum. That is, these interventions are established as effective.” (p. 34)

National Autism Center. (2015). *Findings and conclusions: National standards project, phase 2*. Randolph, MA: Author.

In 2017, the **Ontario Association for Behavior Analysis** conducted a review of the research evidence and best practices for the treatment of autism spectrum disorder. This panel also separated their review into various age groups and identified evidence-based practices in both the age ranges of 6 to 14 and 15 to 22. The main recommendations and findings of this task force were:

“Only those interventions that meet the standards of evidence-based practice should be supported. Commentary: As noted in previous reports, the vast majority of evidence-based interventions consist of applied behaviour analysis (ABA) or incorporate established behaviour analytic procedures. These interventions are often described as either focused ABA interventions or comprehensive ABA interventions.” (p. 93)

“The interventions that we have accepted as evidence based are shown in Tables 6 and 7 and are: comprehensive behavioral treatment for young children (EIBI) and the following focused ABA interventions: cognitive behavioural intervention, differential reinforcement (DRA, DRI, DRO), discrete trial teaching, extinction, functional behaviour assessment, language training, modeling, naturalistic teaching, parent training, peer-mediated intervention, Pivotal Response Treatment® (PRT), visual schedules, scripting, self-management, social skills training, story-based intervention, prompting, reinforcement, response redirection, structured play groups, task analysis, time delay, video modeling, exercise, functional communication training, Picture Exchange Communication System® (PECS), and technology-based intervention.” (p. 94)

Ontario Association for Behaviour Analysis. (2017). *Evidence-Based Practices for Individuals with Autism Spectrum Disorder: Recommendations for Caregivers, Practitioners, and Policy Makers*. Toronto, ON: Author.

IV. These additional 372 studies and reports extend the evidence base for ABA as part of the community standard of care for the treatment of persons who suffer from autism in adulthood.

While this summary includes studies up to the present day, some of the following studies and reports were published as early as the 1980's, which underscores the long and substantial role of ABA treatment as part of the community standard of care for adults who suffer from autism and other developmental disorders.

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- Anderson, A., Dennis W. Moore, Vanessa C. Rausa, Simon Finkelstein, Shaun Pearl, Mitchell Stevenson (2017). A systematic review of interventions for adults with autism spectrum disorder to promote employment. *Review Journal of Autism and Developmental Disorders*, 4, 26-38.
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