

Applied Behavior Analysis Utilization Workgroup

Meeting #2
October 6, 2026

Agenda

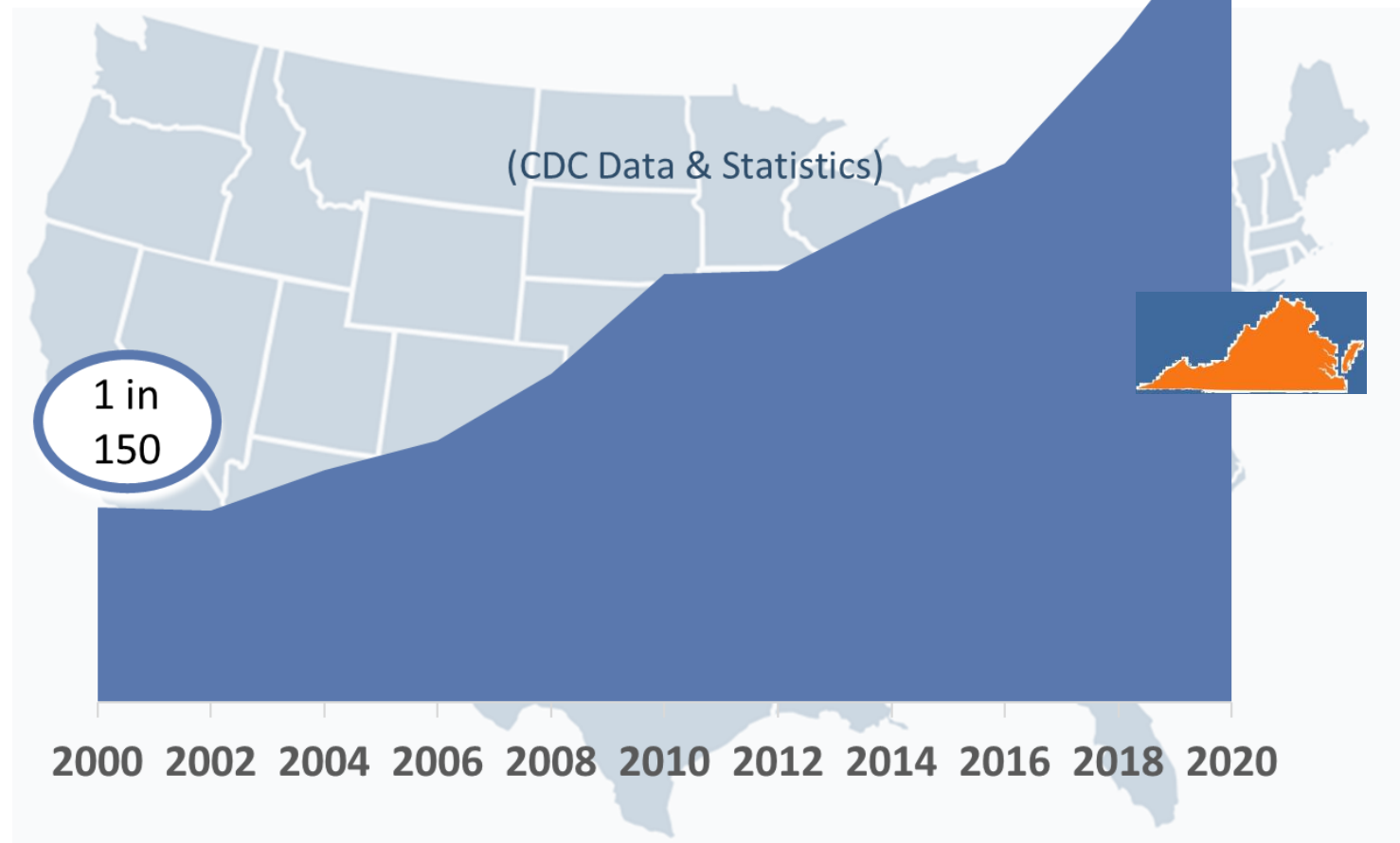
- **Welcome and Introductions**
Shamika Ward, MS (DMAS)
- **Diagnosis of Autism Spectrum Disorder (ASD) and Provisional Diagnoses**
Jitendra Annaparaeddy, MD, MRCPSYCH (Centra Medical Group Autism and Developmental Center);
Beth Ellen Davis, MD, MPH (Developmental Behavioral Pediatrics; UVA Health)
- **Research Review: Efficacy of ABA, and Moderators of Efficacy**
David Bicard, Ph.D., BCBA-D, LBA (Humana)
- **Research Review: Efficacy of ABA for ASD and Non-ASD Diagnoses and Related Factors for Efficacy of ABA**
Charlene Brown, MD, MPH (Anthem/Carelon)
- **Public Comment and Wrap Up**

Medical Assessment of Autism in Virginia

Dr. Jitendra Annapareddy MD
MRCPSYCH
Medical Director
Centra autism and
developmental services

Dr. Beth Ellen Davis MD MPH
Division Director, NDBP, UVA
Developmental Behavioral
Pediatrics

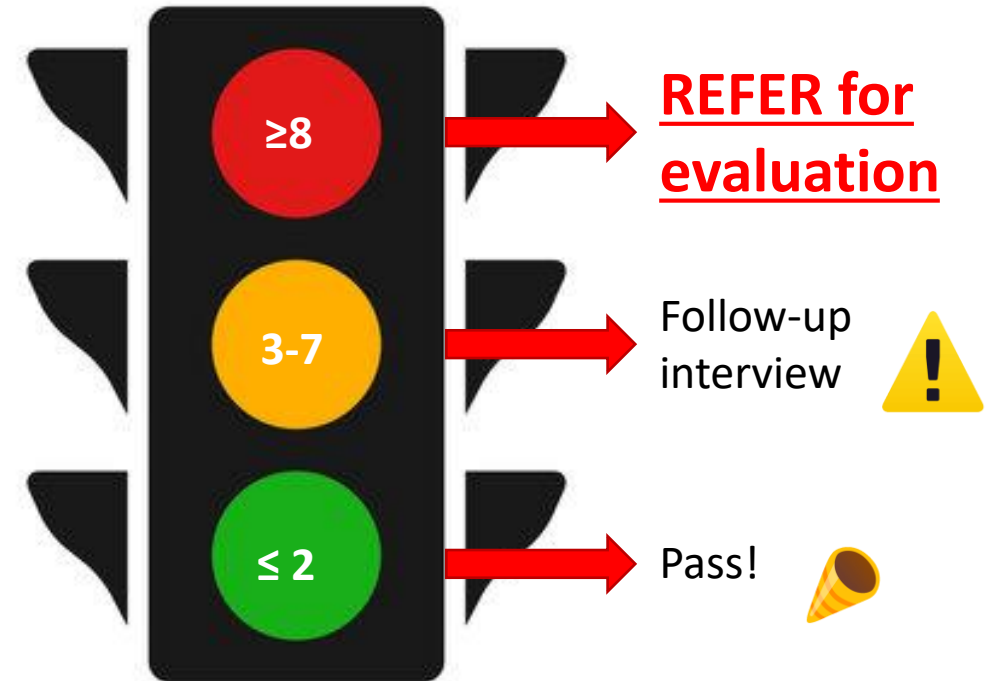
Autism Prevalence



Maenner et al, 2023. Zeidan et al, 2022. NSCH 2020-21.

Primary Care SCREENING

- AAP and Bright Futures recommend screening with an autism-specific tool at
 - 18 and 24 months
 - Any time a parent raises a concern
- Most commonly used tool – M-CHAT-R/F
 - Use it early! (16-30/36 months)
 - Use it at multiple time points (serial screenings)!
 - Use the Follow-up interview!
 - Counsel parents on what the M-CHAT-R/F result means!

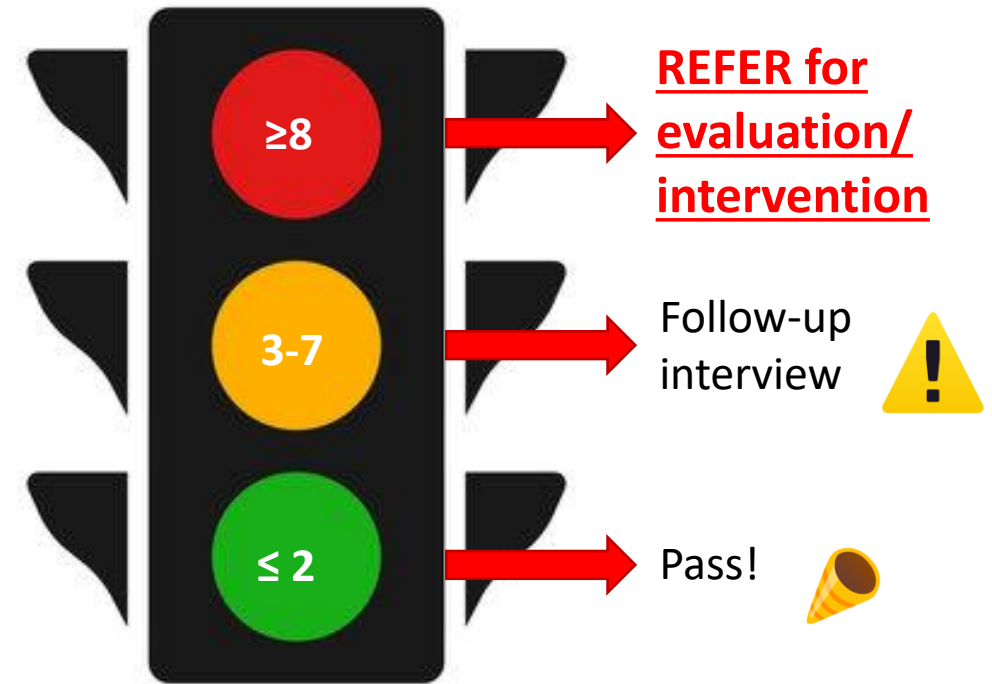


“Screen-Refer-Treat” Model

“While you wait” Do not delay!

- Early Intervention (0-3)
- Child Find (Early Childhood Special Education) (2-3+)
- Audiology
- Speech Language Pathology
- Occupational Therapy

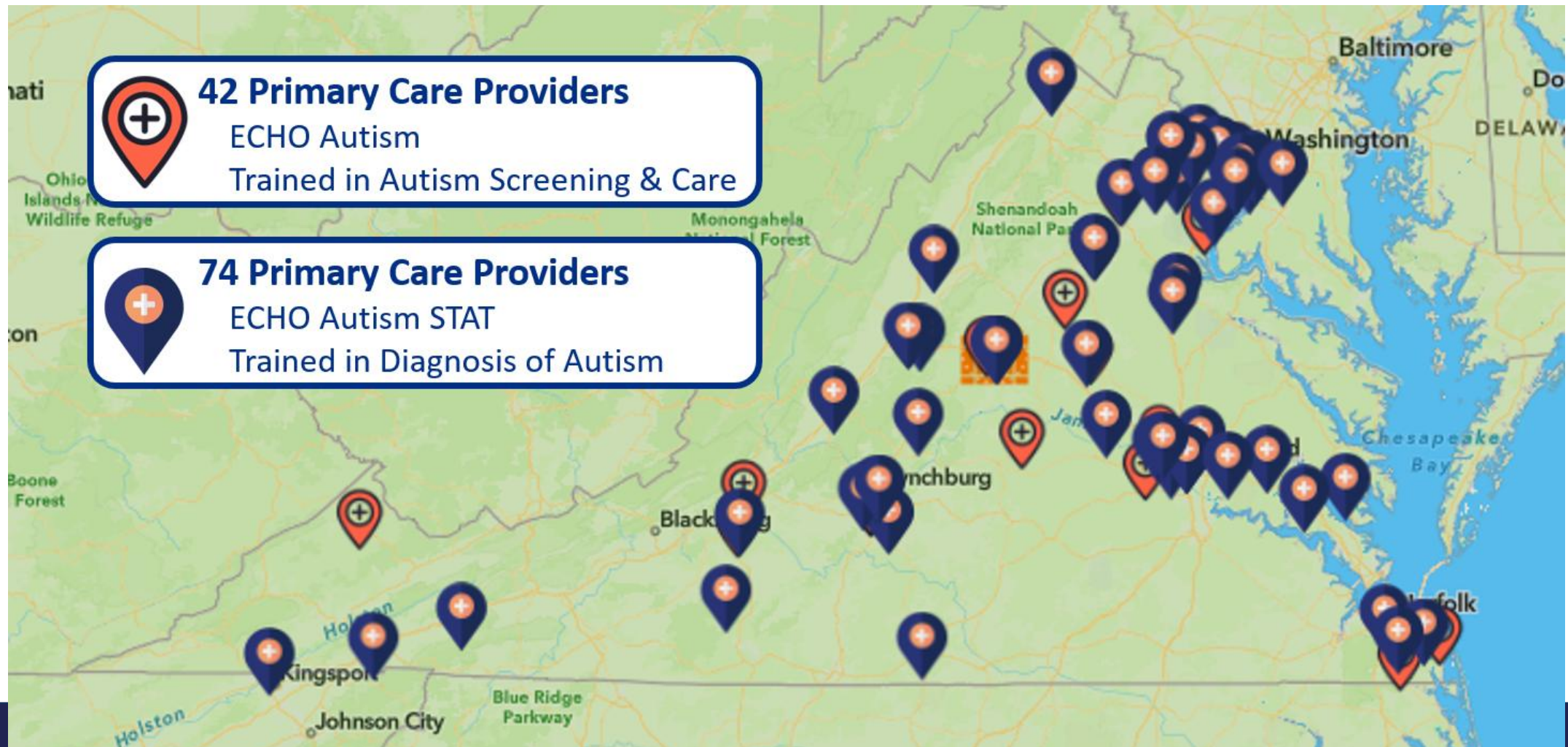
These steps do not require an autism diagnosis!!



STAT training of PCCs

- Screening Test for Autism in Toddlers is a 20/30 minute , 12- prompt DIRECT interaction testing with trained clinician, to demonstrate DSM-5 TR criteria for ASD, in addition to caregiver interviews, medical examination, and general developmental screening.
- Strong evidence for ages 24-36 months.
- 2 day intensive course, test kit required, score provided
- 2 video certifications required of administration
- 8 months of biweekly 90 minute virtual sessions presenting cases and discussing diagnosis and treatment.
- Used for 30-40% of young children with Autism concerns who have clear unambiguous presentation because they are under age 4, had a MCHAT >8, and are functionally non verbal (do not use words to request).

ECHO Autism + ECHO Autism STAT



List of CDCs and other Centers who see at least 50% young children on Medicaid.

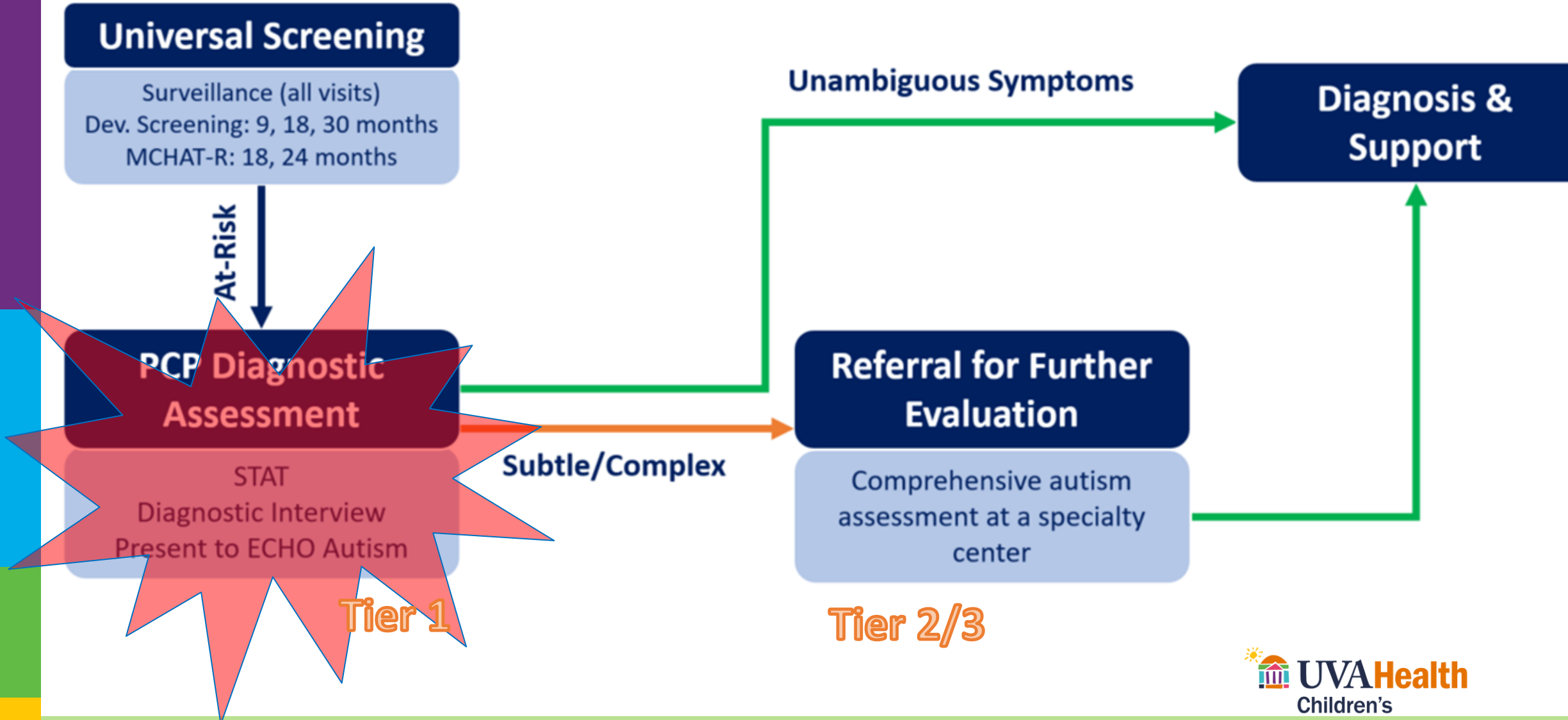
VDH Child Development Centers

Location	Clinic	Phone	Fax
<u>Gate City</u>	Southwest Virginia Child Development Clinic	(276) 386-8010	(276) 386-2116
<u>Harrisonburg</u>	Shenandoah Valley Child Development Clinic (JMU)	(540) 568-6687	(540) 568-3875
<u>Norfolk</u>	Children's Specialty Group Child Development Centers (CHKD)	(757) 668-7473	(757) 668-7474
<u>Richmond</u>	Virginia Commonwealth University Child Development Clinic	(804) 827-2100	(804) 827-2102
<u>Roanoke</u>	Pediatric Neurodevelopmental Clinic (Carilion)	(540) 769-0976	(540) 857-5386

Other Centers

- [UVA Developmental Pediatrics Clinic in Charlottesville](#)
- [Centra Developmental Pediatrics in Lynchburg](#)
- [Children's National Developmental Pediatrics in Washington, DC](#)
- [Inova Children's Developmental Pediatrics in Fairfax](#)
- [CHKD and CHoR are CDCs](#)

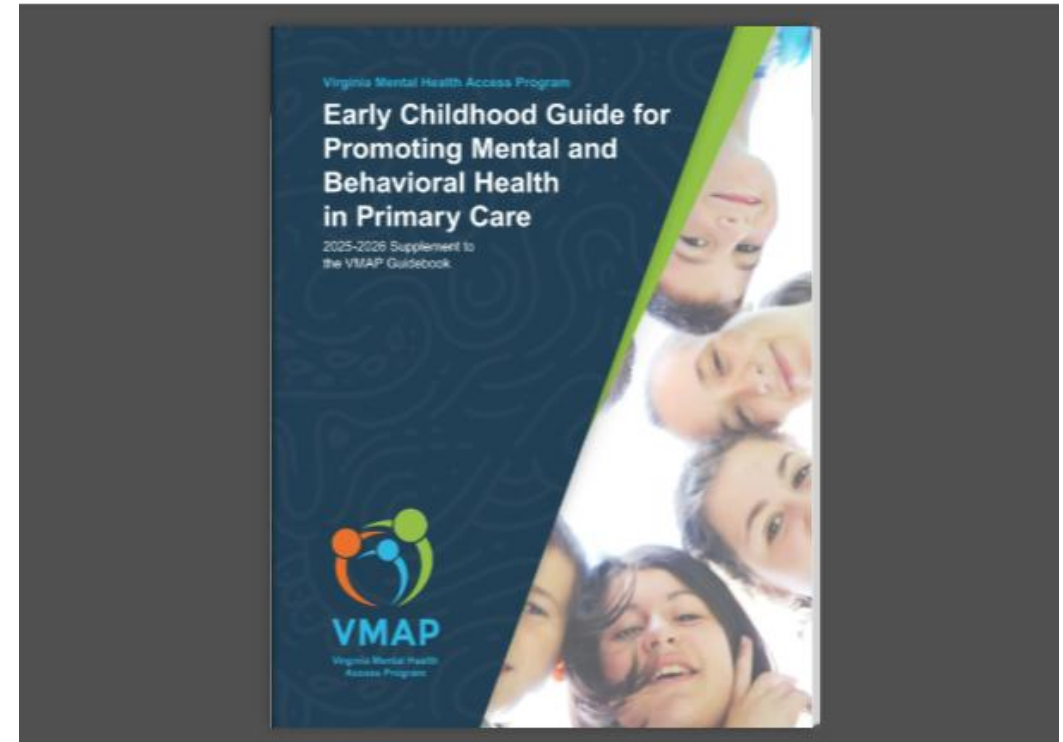
Multi-Tiered Diagnostic Process



VMAP is here to help!

 VMAP FOR MOMS+	 VMAP VIRGINIA MENTAL HEALTH ACCESS PROGRAM	 APAL ADULT PSYCHIATRIC ACCESS LINE
VMAP for Moms+ <i>Pregnancy & Postpartum</i>	VMAP <i>Children & Adolescents</i>	APAL <i>Adults</i>
 888-371-8627 x 1	 888-371-8627 x 2	 888-371-8627 x 3
Connect with: <ul style="list-style-type: none">- Perinatal psychiatrists- Perinatal Licensed Mental Health Professionals (LMHPs)- Care navigators	Connect with: <ul style="list-style-type: none">- Child/adolescent psychiatrists- LMHPs- Care navigators  Press 2, then 6 to access our Early Childhood hub for patients under 6!	Connect with: <ul style="list-style-type: none">- Adult psychiatric specialists- Clinical pharmacists- Addiction medicine specialists (18+)- LMHPs- Care navigators

Early Childhood Guidebook



DOWNLOAD NOW

Care Navigation for busy PCCs

- Finding an autism assessment
- Finding autism-specific community resources for STAT providers and others
- Finding supports for ongoing care, co-occurring conditions, and family



Clinician Call Line
M-F, 9-5
CALL 1-888-371-VMAP

VMAP Early Childhood HUB

PRESS 6 (for kids under 6)

DBP / CHILD PSYCHIATRY ON LINE
1 PSYCHOLOGIST /LMHP
3 CARE NAVIGATORS

TALK WITH REGIONAL HUB TEAM
CHILD PSYCHIATRY/LMHP/CN +

New Statewide CN FOR OLDER KIDS



A rising count does not mean teens are being identified on time

1 in 31

8-year-olds identified with autism in 2022 across CDC surveillance sites

47 months

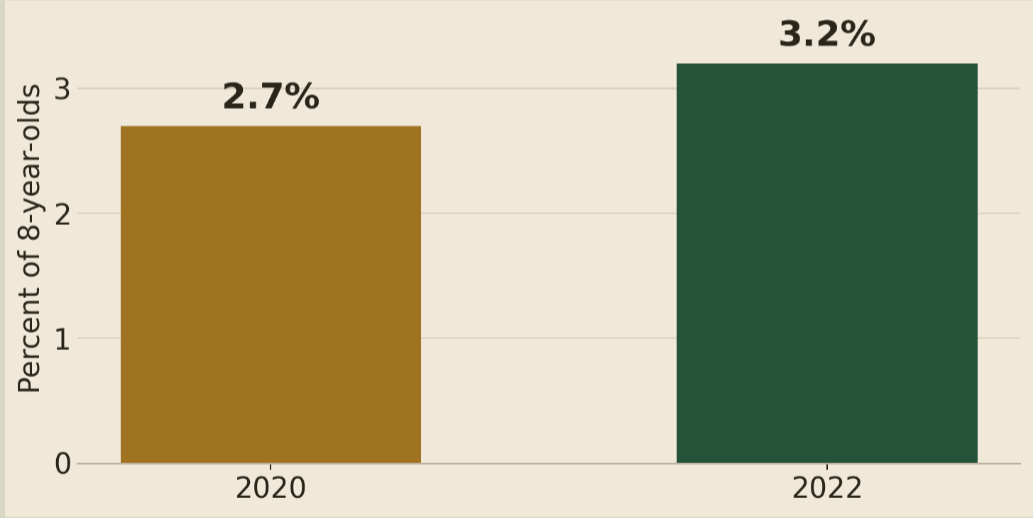
Median age of earliest known diagnosis in the same national surveillance data

3.4×

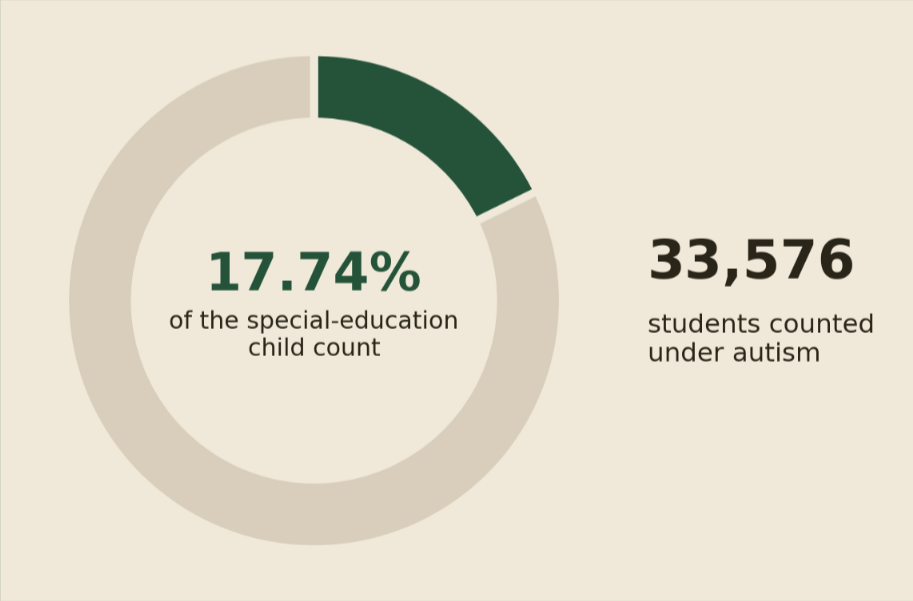
Higher identification among boys than girls, signaling persistent recognition differences

Demand is rising, but Virginia's teen baseline is still indirect

National identification rose between surveillance years



Virginia schools provide the clearest statewide count



Sources: CDC ADDM 2020 and 2022 surveillance; VDOE FFY 2024 Part B SPP/APR. The Virginia figure is educational eligibility, not clinical prevalence.

The data gap hides where adolescent delays accumulate

1

Surveillance follows younger cohorts

The widely cited ADDM estimate describes 8-year-olds in selected communities, not Virginia teens.

2

Schools count eligibility

VDOE tracks students receiving IDEA services; the count does not equal a medical diagnosis registry.

3

Clinical capacity is fragmented

Wait times, referral volume, and completion rates are not reported in one statewide teen dataset.

4

Equity is hard to audit

Without age, region, payer, race, language, and disability detail, hidden delays stay hidden.

Referral should begin when demands outpace coping

- | | | |
|---|--|--|
| 1 | Look for a pattern | Concerns appear across relationships, routines, learning, sensory environments, or recovery after demands. |
| 2 | Ask about developmental history | Current distress matters, but autism criteria also require a developmental pattern, even when early signs were subtle. |
| 3 | Assess functional impact | Escalating school avoidance, exhaustion, isolation, shutdowns, or loss of independence can justify referral. |
| 4 | Compare settings | Home, school, work, and peer contexts may reveal very different levels of effort and support. |
| 5 | Escalate regression | Language or motor regression requires medical evaluation; do not route it as a routine autism-only question. |

Adolescence changes how autism may become visible



Social complexity rises

Nuance, rapid group conversation, dating, and shifting peer rules can expose previously supported differences.

Executive load rises

Multiple teachers, long projects, transport, and self-management increase planning demands.

The cost may be delayed

A teen can appear composed at school and still experience exhaustion, shutdown, or distress afterward.

Strong language and eye contact do not rule autism out

Visible competence can coexist with substantial effort, support needs, and loss of function.

- Good eye contact, affection, or typical language milestones do not rule out autism.
- Girls and verbally able youth may be under-recognized.
- Masking and a highly supportive environment can conceal differences until demands rise.
- Anxiety, depression, perfectionism, or school refusal may be the presenting concern.
- New information can justify reconsidering an earlier negative assessment.

Virginia's bottleneck is a pathway problem, not one waitlist

National access signal

Nearly two-thirds

of autism centers reported waits longer than four months.

More than 15%

reported waits beyond a year or no ability to join a list.

Virginia pathway friction

- Families navigate scattered referral and support resources.
- Specialist capacity is uneven across regions and payers.
- School, behavioral health, and medical documentation may not travel together.
- Late-teen referrals can collide with transition to adult services.

The wait figures are national context cited in Virginia reporting—not a statewide Virginia wait-time measure.

A better model distributes expertise without diluting rigor

Distribute diagnostic expertise

Support competent general pediatric and behavioral-health clinicians to evaluate clearer presentations, with consultation available.

Reserve specialty care

Prioritize regression, complex medical or psychiatric presentations, diagnostic uncertainty, and contested histories.

Complete prework once

Collect developmental history, school records, rating scales, hearing or vision information, and prior testing before the visit.

Return one usable plan

Share findings with the teen and family, identify immediate supports, and route medical, school, and transition actions without restarting the story.

Choose by goal, not by label

A “high-” or “low-functioning” label cannot tell us whether the immediate target is communication, anxiety, self-care, learning, sensory access, safety, or participation.

The treatment plan should.

Functional level is a profile, not a rank

Communication

Speech, AAC, comprehension, self-advocacy

Cognition and learning

Learning style, pace, generalization

Adaptive skills

Self-care, home, travel, money, safety

Regulation and sensory access

Arousal, pain, environment, recovery

Mental and physical health

Anxiety, ADHD, sleep, GI, seizures

Context and autonomy

Supports, preferences, culture, consent

A person may need substantial support in one domain and little in another; reassess across settings and over time.

ABA is a toolkit, not one standardized treatment

Focused ABA strategies

- Functional assessment
- Reinforcement, prompting, modeling
- Functional communication training
- Task analysis and self-management

Best fit: a defined, observable goal.

Comprehensive ABA programs

- Multiple goals across many hours
- May use discrete-trial and naturalistic teaching
- Often called EIBI when intensive and early
- Quality, goals, and implementation vary widely

Evidence question: do gains generalize and matter to the person?

DSM-5 TR Autism Spectrum Disorder

A

Persistent deficits in social communication and social interaction across context, not accounted for by general developmental delays and manifested by **all 3** of the following:

1. **Deficits in social-emotional reciprocity**; ranging from abnormal social approach and failure of normal back and forth conversation through reduced sharing of interests, emotions, and affect and response to total lack of initiation of social interaction.
2. **Deficits in nonverbal** communicative behaviors used for social interaction; ranging from poorly integrated- verbal and nonverbal communication, through abnormalities in eye contact and body-language, or deficits in understanding and use of nonverbal communication, to total lack of facial expression or gestures.
3. **Deficits in developing and maintaining relationships**, appropriate to developmental level (beyond those with caregivers); ranging from difficulties adjusting behavior to suit different social contexts through **difficulties in sharing imaginative play** and in making friends to an apparent absence of interest in people

B

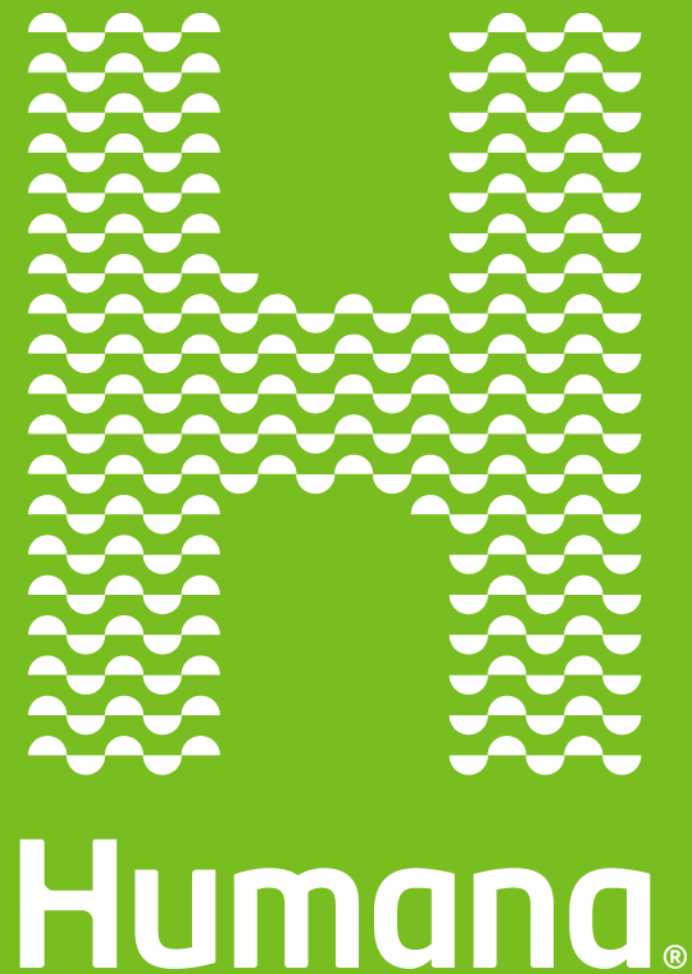
Restricted, repetitive patterns of behavior, interests or activities as manifested by at least **two** of the following

1. Stereotyped or repetitive speech, motor movements, or use of objects; (such as simple motor stereotypies, echolalia, repetitive use of objects, or idiosyncratic phrases)
2. Excessive adherence to routines, ritualized patterns of verbal or nonverbal behavior, or excessive resistance to change; (such as motoric rituals, insistence on same route or food, repetitive questioning or extreme distress at small changes).
3. Highly restricted, fixated interests that are abnormal in intensity or focus; (such as strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
4. Hyper-or hypo-reactivity to sensory input or unusual interest in sensory aspects of environment; (such as apparent indifference to pain/heat/cold, adverse response to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or spinning objects).

C. Symptoms must be **present in early childhood** (but may not become fully manifest until social demands exceed limited capacities)

D. Symptoms together limit and **impair everyday functioning**.

E. ****These disturbances are not better explained by GDD intellectual disability ****

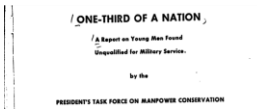


Efficacy and Moderators of ABA therapy for Children with ASD

Contextual Timeline

Society

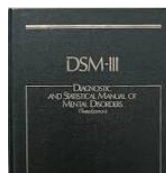
One Third of A Nation Published



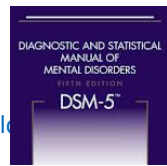
Medicaid

EPSDT

IDEA



ASD covered in IDEA



Demand for ABA therapy exploded

Insurance mandates for ABA therapy (Ryan's Law 2007)

CMS mandates ABA therapy -2014

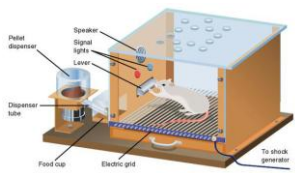
Behavior Analysis

Experimental Analysis of Behavior

Applied Behavior Analysis

← Lovaas UCLA Project

→



THE PSYCHIATRIC NURSE AS A BEHAVIORAL ENGINEER¹
TEODORO AYLLON² and JACK MICHAEL
UNIVERSITY OF HOUSTON



Behavioral Treatment and Normal Educational and Intellectual Functioning in Young Autistic Children

O. Ivar Lovaas
University of California, Los Angeles

SOME GENERALIZATION AND FOLLOW-UP MEASURES ON AUTISTIC CHILDREN IN BEHAVIOR THERAPY¹
O. IVAR LOVAAS, ROBERT KOEGEL², JAMES Q. SIMMONS, AND JUDITH STEVENS LONG³
UNIVERSITY OF CALIFORNIA, LOS ANGELES

TOWARD A FUNCTIONAL ANALYSIS OF SELF-INJURY

BRIAN A. IWATA, MICHAEL F. DORSEY, KEITH J. SLIFER, KENNETH E. BAUMAN, AND GINA S. RICHMAN

State funding for ABA BACB HCBW Programs

Samuel Gridley Howe,

childhood schizophrenia, boarding schools

Autism

1800



1908

Kanner/Asperger papers "Refrigerator Mother" syndrome

1950s

1964

1967

1973

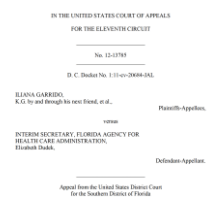
1987

1994

2010

2020

K.G. vs. Dudek Settled



Caregivers organize



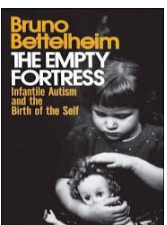
Victor, The Wild Boy of Aveyron

1846



Bleuler coined autism Textbook of Psychiatry

1933-1934



1959



Rimland Redefines ASD

1965

1972

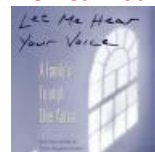
First ASD DX in DSM

1980

1 in 2,500

1990

Let Me Hear Your Voice



1 in 1,000

2000

1 in 150

2012

1 in 68

2022

1 in 36 1 in 31

History of Treatment for ASD

1850s-1970s – Institutionalization and Psychoanalysis for Parents

- ASD thought largely untreatable
- “Refrigerator Mother Syndrome” (1940s-1970s)



1970s-1990s - Era of Fad Treatments

- Special Education in schools (not a fad treatment)
- Small scale treatment with ABA, mostly university research (not a fad treatment)
- Rebirthing, holding therapy, brushing therapy, body socks
- Chelation – vaccine myth
- Prism glasses, hyperbaric chambers, special diets, facilitated communication, DAT



1990s-Today- Evidence Based Practices and Neurodiversity Acceptance

- ABA therapy
- Multimodal treatment – Speech, OT, Caregiver Support Services, Medication
- Recognition and acceptance of neurodiversity in our society



Overall Efficacy of ABA therapy for Children with ASD

- Collins et al. (2025) – Meta Analysis of 25 published studies of behavior analysis for children ASD
 - Strongest positive outcomes (Large to moderate effect sizes)
 - Adaptive behavior
 - Communication/language
 - Cognitive functioning
 - Acquisition of functional skills
 - Weaker positive outcomes (small effect sizes)
 - Core autism symptoms
 - Social reciprocity
 - Long-term independence
 - Quality of life outcomes
 - Generalization across settings
 - **Importantly, greater cumulative treatment dose and longer duration were associated with larger gains in adaptive behavior**

Overall Efficacy of ABA therapy for Children with ASD

- Building on Eldevik et al. (2010), Eldveik et al (2026) found EIBI to produce
 - Strongest positive outcomes (Large to moderate effect sizes)
 - Reduction in ASD symptoms
 - Adaptive behavior
 - IQ or intellectual functioning
 - **Treatment intensity was strongly positively correlated with better outcomes across all measures**
- Pruneti, Coscioni, & Guidotti S (2023) – Systematic review of RCD and SC studies across many applications of ABA models found generally strong positive in developmental outcomes

Practical conclusion

- The vast majority of all the research on the efficacy of ABA therapy show it to be a robust intervention model for treatment of Autism with moderators of its overall effectiveness

Moderators of Efficacy

Research indicates that treatment efficacy is not uniform; it is heavily moderated by baseline participant traits, intervention delivery variables, and environmental contexts.

- **Age at onset of treatment**

- **Early Intervention Advantage:** Children who begin ABA-based programs at a younger age (typically under 3–4 years old) demonstrate significantly greater gains in IQ, language, and adaptive function compared to older peers. Early neuroplasticity and the early targeting of foundational "learning to learn" skills drive this effect.
- **Age-Dependent Focus:** Recent causal moderation analyses suggest that age interacts with treatment intensity rather than acting independently. Younger children may benefit somewhat more efficiently from higher-intensity instruction, but older children still demonstrate meaningful skill acquisition when intervention targets are appropriately selected

Practical conclusion

Age at onset of treatment appears to be:

- A moderate predictor of response
- Particularly relevant for language and cognitive outcomes
- Less predictive for acquisition of specific functional skills later in development

Moderators of Efficacy

- **Treatment Dose and Intensity**

- **Comprehensive EIBI:** High-intensity protocols (traditionally 20–40 hours per week) show dose-dependent improvements in cognitive and adaptive outcomes in controlled clinical trials. Recent meta-analyses confirm that total cumulative dose and duration predict greater improvements in adaptive behavior.
- **Threshold & Diminishing Returns:** Real-world data (RWD) and observational studies suggest a non-linear relationship. Beyond a certain point (or without high-quality implementation), additional hours do not strictly translate to linear gains. Treatment dosage must be individualized rather than universally applied at maximum capacity

* A word on Sandbank, Pustejovsky, and Bottema-Butel (2024). Large meta-analysis that found weak effects for dose/intensity and outcome. A re-analysis of Sandbank et al.'s data was done by Frazier, Chetcuti, and Ulijarevic (2024) who found that if IQ was controlled for, there was a consistent moderate to large effect based on dose/intensity

Moderators of Efficacy

Treatment Dose and Intensity

Practical conclusions

The literature suggests:

- High-quality intervention × good child-treatment fit may be more important than simply increasing hours
- Positive dose-response relationships for adaptive behavior
- Better outcomes with sustained intervention duration

But

Intensity likely has:

- Diminishing returns
- Strong individual variability
- Dependence on developmental readiness/IQ and treatment quality

Moderators of Efficacy

Setting as a Moderator - Not a lot of consensus in the literature. In general, and with a lot of caveats:

Clinic-Based ABA

Advantages:

- High procedural fidelity
- Consistent staffing
- Intensive teaching opportunities

Limitations:

- Generalization difficulties

School-Based ABA

Advantages:

- Natural peer context
- Educational relevance
- Greater generalization

Limitations:

- Competing academic demands
- Staff training variability

Home-Based ABA

Advantages:

- Greater ecological validity
- Improved caregiver participation
- Better opportunity for functional behavior change

Limitations:

- Variable implementation quality
- Family burden

Practical Conclusions

Overall, evidence increasingly favors:

- High treatment fidelity
- Multiple-setting implementation
- Strong generalization programming

Yields better outcomes rather than reliance on any **single** setting

Moderators of Efficacy

ASD Severity Level (1, 2, 3)

Baseline developmental level appears to be among the strongest moderators.

Children with:

- Higher cognitive skills
- Better receptive language
- Stronger adaptive skills

often make larger absolute gains.

However:

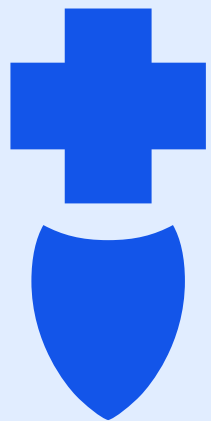
Children with more significant impairments may demonstrate:

- Larger relative gains
- Greater reductions in barriers to learning (maladaptive behaviors)
- More clinically meaningful improvements despite smaller standardized effect sizes.

Bottom-Line Clinical Conclusions

The best-supported conclusions from current evidence are:

1. ABA-based interventions produce meaningful average improvements in adaptive behavior, language, cognitive skills, and functional abilities.
2. Earlier intervention is generally associated with better outcomes, especially for language and cognitive development.
3. Recent evidence challenges the assumption that simply increasing hours automatically improves outcomes. Quality and fit appear at least as important as intensity.
4. Baseline language, cognitive functioning, and adaptive skills are among the strongest predictors of treatment response.
5. Caregiver-mediated approaches are increasingly supported and may achieve comparable outcomes with lower intensity in some populations.
6. Treatment response is best conceptualized as an interaction among age, developmental level, family involvement, intervention type, setting, and dose, rather than any single factor determining success.



The Efficacy of Applied Behavior Analysis (ABA)

Evidence for ASD & Non-ASD Diagnoses

ABA for ASD: What the Evidence Shows

- Multiple systematic reviews and meta-analyses demonstrate that ABA-derived and ABA-informed interventions result in meaningful benefits for many children with ASD, particularly young children.
- **The evidence is strongest when treatment is:**
 - ✓ targeted to specific functional outcomes
 - ✓ individualized
 - ✓ monitored for measurable progress
- **The magnitude and strength of benefit vary by outcome.**

ABA for ASD: What the RCT Evidence Shows

Systematic review and meta-analysis of 16 randomized controlled trials

✓ **Statistically significant improvements, generally small improvements**

✓ Adaptive behavior

✓ Daily living skills

✓ Language

✓ Joint attention

Evidence quality varied by outcome

Moderate: Language

Low: Adaptive behavior, daily living, socialization, joint attention

Autism symptom severity

Overall autism symptom severity did not show a statistically significant improvement

Key message: ABA-derived interventions show benefit for selected functional outcomes, but effects are generally small and evidence certainty varies by outcome.

Where ABA Shows Benefit for ASD

2025 meta-analysis of 25 controlled studies

Effects varied substantially by outcome. Benefits were more evident in developmental and adaptive domains than in overall autism symptom severity.

Outcome	Standardized Effect Estimate
Receptive language	0.74
Cognitive outcomes	0.65
Adaptive communication	0.63
Socialization	0.52
Daily living	0.48
Autism symptom severity	-0.30

Interpretation for practice: ABA benefits are outcome-specific; treatment goals should identify the functional domain being targeted.

Factors Associated with Efficacy in ASD

Who and what is targeted

- **Age and developmental level** — strongest evidence is in young children.
- **Clearly defined, individualized targets** — focus on functionally meaningful goals.
- **Baseline functioning and severity** — children with greater needs may require greater levels or different types of support.

How treatment is delivered

- **Treatment fidelity** — consistent, high-quality implementation matters.
- **Generalization** — skills should extend beyond the clinic to home, school, and community.
- **Ongoing reassessment** — treatment should be adjusted based on progress.

No Well-Established Universal Dose-Response Relationship

- A 2024 meta-analysis of 144 early-childhood autism intervention studies, including behavioral and other nonpharmacologic approaches, found no significant positive association between intervention amount and effect within intervention type.
 - ✓ **Key takeaway:** Across the available population-level evidence, more intervention hours did not reliably predict greater benefit.
- Intensity should be individualized based on clinical need, not fixed hour thresholds.
- Hour thresholds alone are a poor proxy for clinical benefit.

Non-ASD Spending is Concentrated in ADHD

CMS ABA Toolkit Appendix C shows a striking concentration in ADHD and disruptive/developmental diagnoses.

57%

of all non-ASD ABA spending
(2021–2025) was associated
with five ADHD diagnosis
codes

40.3%

ADHD combined type alone

Top diagnoses in CMS claims data

ADHD, combined type	\$1.247B	19,189 beneficiaries
Other disorders of psychological development	\$262M	6,729 beneficiaries
ADHD, inattentive type	\$137M	2,785 beneficiaries
Oppositional defiant disorder	\$121M	2,878 beneficiaries
ADHD, hyperactive type	\$115M	2,358 beneficiaries
ADHD, unspecified	\$105M	2,912 beneficiaries

ABA in Non-ASD Diagnoses: Evidence Is More Limited and Target-Specific



Focused ABA Has Evidence for Selected Clinical Targets

- ID/DD with severe aggression or self-injury
 - Substantial evidence base supports functional assessment and focused, function-based treatment of severe problem behavior.
 - Treatment targets the behavior's function such as escape, attention, access to tangibles, or sensory reinforcement.
- For other non-ASD diagnoses, limited evidence may support focused behavioral strategies for specific behaviors.
- This does not establish comprehensive, high-intensity ABA as a diagnosis-level treatment.



Current evidence does not support comprehensive, high-intensity ABA as a standard diagnosis-level treatment for:

- ADHD
- Oppositional defiant disorder or conduct disorders
- Primary language disorders
- Feeding disorders
- Insomnia
- Toileting difficulties
- Anxiety, depression, or other psychiatric disorders



Other Evidence-Based Treatments Exist and Should Be Prioritized

ADHD: parent training in behavior management, behavioral classroom interventions, organizational-skills interventions, and medication when clinically indicated

Disruptive behavior: PCIT, parent management training

Language/communication: speech-language therapy

Feeding: multidisciplinary feeding programs

Sleep: behavioral sleep treatment

Anxiety/depression/OCD/PTSD: CBT and psychotherapies

Returning to ASD: Key Takeaways

- ABA is an important, evidence-based treatment option for ASD.
- Benefits are demonstrated, but outcome-specific and variable in magnitude.
- Treatment should be individualized, with clearly defined, measurable goals.
- There is no universal dose threshold; intensity should match clinical need.
- Ongoing monitoring and reassessment ensure meaningful, generalizable progress.
- For non-ASD diagnoses, evidence for comprehensive ABA is limited; focused behavioral treatment may be appropriate for selected targets, while diagnosis-specific evidence-based treatments should be prioritized.
- The goal is the right intervention, for the right behavioral target, at the right intensity, with measurable real-world benefit.

References

Core ASD ABA evidence and treatment intensity

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Public Comment

Workgroup Meeting #3 10/27/26

Public Comment on Town Hall

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Thank you!

