Using Diagnostic Reports to Inform your ABA Assessment

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What You’ll Learn

• Review DSM-V Autism Spectrum Disorder Criteria
• Key Features of a Diagnostic Report
• How BCBAs can use Diagnostic Reports to inform their tx plan
• How Psychologists can support effective ABA assessments
Autism Spectrum Disorders

- Neurodevelopmental Disorder
- Behavioral Diagnosis
- Symptoms range from mildly impairing to severely impairing
- The constellation of symptoms can vary from person to person
- People with ASD often have various co-occurring mental, behavioral and physical conditions.
A. Persistent Deficits in Social Communication and Social Interaction

A1. Problems with *social initiation and response*
   “Catch and Serve”

A2. Problems with *non-verbal communication*
   How do we communicate when we don’t speak the same language?
   How do we communicate what’s not being said?

A3. Problems with *social awareness and insight*
   How does my behavior affect others and how does their behavior affect me?
B. Restricted, Repetitive Patterns of Behavior, Interests or Activities

B1. Atypical *speech, movements, and play*
Often these stand out, but sometimes they do not

B2. Problems with *rituals and resistance to change*
Offers predictability

B3. *Fixated interests*
Objects vs. People

B4. Atypical *Sensory Behaviors*
A different experience of the world
C. Symptoms must be present in early childhood

D. Symptoms together limit and impair everyday functioning across contexts.
   - Level 3 = Requiring very substantial support
   - Level 2 = Requiring substantial support
   - Level 1 = Requiring support

E. Symptoms are not better explained by intellectual disability or global developmental delay.

Specify if:
- With or without accompanying intellectual impairment
- With or without accompanying language impairment
- Associated with a known medical or genetic condition or environmental factor
- Associated with another neurodevelopmental, mental, or behavioral disorder
- With catatonia
<table>
<thead>
<tr>
<th>Severity Level for ASD</th>
<th>Social Communication</th>
<th>Restricted Interests &amp; Repetitive Behaviors</th>
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<tbody>
<tr>
<td>Level 3 'Requiring very substantial support'</td>
<td>Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning; very limited initiation of social interactions and minimal response to social overtures from others.</td>
<td>Preoccupations, fixated rituals and/or repetitive behaviors markedly interfere with functioning in all spheres. Marked distress when rituals or routines are interrupted; very difficult to redirect from fixated interest or returns to it quickly.</td>
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<tr>
<td>Level 2 'Requiring substantial support'</td>
<td>Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions and reduced or abnormal response to social overtures from others.</td>
<td>RRBs and/or preoccupations or fixated interests appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress or frustration is apparent when RRB’s are interrupted; difficult to redirect from fixated interest.</td>
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<tr>
<td>Level 1 'Requiring support'</td>
<td>Without supports in place, deficits in social communication cause noticeable impairments. Has difficulty initiating social interactions and demonstrates clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions.</td>
<td>Rituals and repetitive behaviors (RRB’s) cause significant interference with functioning in one or more contexts. Resists attempts by others to interrupt RRB’s or to be redirected from fixated interest.</td>
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Types of Assessments

**Psychological Evaluation:** Focus is on identifying neurodevelopmental or psychiatric disorders.

**Psychoeducational Evaluation:** Focus is on academic achievement as it relates to general intellectual abilities. When done in a school setting, is not conducted to provide a diagnosis.

**Developmental Evaluation:** Focus on infancy - preschool age children to determine whether or not developing is occurring at expected rates in areas of cognitive, language, motor, social, and adaptive functioning.

**Neuropsychological Evaluation:** Focus is on how behavior is related to specific strengths and weaknesses in brain functioning - not just “what” the problem is, but “why” there is a problem.
Assessment Goals

➔ Establish a diagnosis
➔ Measure and describe functional capacities (strengths and weaknesses)
➔ Measure treatment effects
➔ Help caregivers and providers understand the uniqueness of the child
➔ Make treatment recommendations
Assessment Components

- Clinical / Diagnostic / Developmental History Interview
- Record Review
- Test Selection and Administration
- Interpretation and Integration of test results with clinical data
- Written Report
- Interactive Feedback, including treatment recommendations
Elements of a Psychological Report

- Identifying information
- Referral question
- Background information
- Evaluation procedures
- Behavioral observations / Mental status evaluation
- Test results
- Impressions and Interpretations
- Summary
- Recommendations
Co-morbid Conditions

- ADHD: 30-60% (7% of general)
- Anxiety: 42% (3%)
- Depression: 7% (2%)
- OCD: 17% (3%)
- Bipolar: 7-27% (4%)
- Psychosis: 16%
- Tics & Tourettes: 22% (3%)
- Eating Disorders: 23% (female)

Medical Necessity Determination

Step 1: Initialization of care: Set of criteria that determines if care is needed and at what level treatment should be authorized.

- DSM-5 Diagnosis
  ASD Dx = “Symptoms of the illness are active and result in substantial impairment in daily functioning”

- Severity of Symptoms
  Level 2 Severity Status = “Marked deficits in social communication and restricted repetitive behavior require substantial support to participate in [child’s] home, school, and community”

  Co-morbid diagnoses: “The secondary diagnosis of [ADHD] complicates the severity of [child’s] presentation and will impact treatment intensity and duration.”

- Evaluation content supports payor requirements for obtaining ABA services
Prescription for ABA treatment provided by a Qualified Health Professional

To Whom It May Concern:

I am writing on behalf of my patient, ___________ (DOB: ________). __________ is a _____ year, ____ month old [boy/girl] whose neurodevelopmental profile is consistent with the diagnosis of an Autistic Spectrum Disorder, ICD -10: F84.0. This diagnosis was made by _______________, on _______. Neurologic functioning is presently inadequate for the appropriate language, social, and play skills typical of children’s age. The severity of his/her disorder results in [mild/moderate/severe] impairments in developmental functioning.

This letter is written to serve as a prescription for ABA therapy. ABA services are medically necessary to prevent deterioration of function and allow _______ to make optimal neurobehavioral gains that will reduce symptom severity. The National Research Council has also recommended that [his/her] parents become skilled in behavior modification in an outpatient setting. Thirty years of research has demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior, increasing communication, learning, appropriate social behavior, and generalizing behaviors across environments. These interventions are medical, not educational, and facilitate functioning in home and community settings.

Please let me know if I may be of further assistance,
Medical Necessity Determination

Step 2: Maintenance of Ongoing Care: Should care continue at the current level?

Re-evaluation can support:
- Identification of co-morbid diagnoses
- Normed assessments of functioning across developmental domains
- Response to treatment
- Family acclimation to treatment

When to refer for a re-evaluation?
- Not making expected progress
- Additional symptoms are identified
- Child is older and can participate in more thorough or more valid testing
- During developmental transition periods
- Additional data needed to determine and support appropriate levels of care
Medical Necessity Determination

Step 3: Change or Termination of Care: Criteria that determines if care should change.

Decisions may be impacted by:

- Intellectual Functioning
- Specific Developmental Disabilities
- Mental Health / Psychiatric diagnoses
**Common Intelligence Tests:**

- Wechsler Intelligence Tests
- Stanford Binet Intelligence Tests
- Woodcock Johnson Tests of Cognitive Disabilities
- Differential Ability Scales

Intellectual Disability

Diagnosis is made with by intellectual ability + adaptive functioning. DSM-5 places more reliance on the ability to independently manage skills of daily living.

Mild Intellectual Disability  IQ = 50-69  (minimal support)
Moderate Intellectual Disability  IQ = 36-49  (moderate support)
Severe Intellectual Disability  IQ = 20-35  (daily assistance for self-care and safety)
Profound Intellectual Disability  IQ = < 20  (requires 24 hour care)
Normal Curve Distribution

T Score: Tells you how far away a score is from the mean & allows you to compare a given score to scores received by others.

69 and Below = Extremely Low
70-79 = Borderline
80-89 = Low Average
90-109 = Average
110-119 = High Average
120-129 = Very High
130-144 = Extremely High
# Intellectual Disability - Determining Severity

**DSM 5 Guidelines**

<table>
<thead>
<tr>
<th>Conceptual Domain</th>
<th>Social Domain</th>
<th>Practical Domain</th>
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<tbody>
<tr>
<td><strong>Mild</strong></td>
<td>In preschool children, there may be no obvious conceptual differences. For school-age children and adults, there are difficulties in learning academic skills needed to meet age-related expectations. In adults, abstract thinking, executive function (e.g., planning), and short-term memory, as well as functional use of academic skills are impaired.</td>
<td>Compared with typically developing age-mates, the individual is immature in social interactions. For example, there may be difficulty in accurately perceiving peers’ social cues. Often noticed by peers, there may be difficulties regulating emotion and behavior in age-appropriate fashion.</td>
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<tr>
<td><strong>Moderate</strong></td>
<td>All through development, the individual’s conceptual skills lag markedly behind those of peers. Ongoing assistance on a daily basis is needed to complete conceptual tasks of day-to-day life, and others may take over those responsibilities throughout the lifespan.</td>
<td>Friendships with typically developing peers are often affected by communication or social limitations. Significant social and communicative support is needed in work settings for success.</td>
</tr>
<tr>
<td><strong>Severe</strong></td>
<td>Attainment of concepts is limited (e.g., money, time, quantity). Caretakers provide extensive supports for problem solving throughout life.</td>
<td>Spoken language is quite limited in terms of vocabulary and grammar. Speech may be single words or phrases, and communication are focused on the here and now within everyday events. Relationships with family members and familiar others are a source of pleasure.</td>
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<tr>
<td><strong>Profound</strong></td>
<td>Conceptual skills generally involve the physical world rather than symbolic processes. The individual may use objects in goal-directed fashion for self-care, work, and recreation. Motor and sensory impairments may prevent functional use of objects even if certain visuospatial skills are intact (e.g., can match objects based on physical characteristics seen visually, but cannot translate to appropriate use).</td>
<td>The individual has very limited understanding of speech or gesture. He or she may understand some simple instructions or gestures, and expresses his or her own desires and emotions largely through nonverbal, nonsymbolic communication. The individual enjoys relationships with well-known family members &amp; caretakers primarily.</td>
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Intellectual Disability: Mental Age / Chronological Age

Mental Age is a measure of a person’s mental abilities compared to the average intellectual performance for someone of their actual chronological age. Calculating a child’s mental age can be broadly helpful for creating curriculum and developing expectations around adaptive functioning. The formula is:

\[
IQ = \frac{\text{Mental age}}{\text{Physical age}} \times 100
\]

When someone’s IQ is average (IQ=100), their mental age and physical age are the same. If someone is 10 years old, and has a mild intellectual disability (for example, IQ = 65), their chronological age would be 6.5. Another 10 year old child with an IQ of 120 would have a mental age of 12.

NOTE: Mental age should only be used in the context of other information about any particular individual, and is only as reliable as the measure of intelligence. Some ASD children score artificially low on intelligence tests until skills needed for testing taking are better developed.
A Diagnostic Report might inform:

- How quickly a goal is met
- The purpose of a behavior
- What kind of stimuli to use
- Interpreting uneven response to treatment
- How to structure the environment
- How to select effective reinforcers
- Successful pairing
## Co-morbid Conditions & ABA Programming

<table>
<thead>
<tr>
<th>Condition</th>
<th>Technique/Strategy</th>
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<tbody>
<tr>
<td>ADHD</td>
<td>Shaping / Environmental Modification</td>
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<tr>
<td>Anxiety</td>
<td>Priming / Errorless learning</td>
</tr>
<tr>
<td>Depression</td>
<td>Goals around positive activities / Exercise</td>
</tr>
<tr>
<td>OCD</td>
<td>Self-monitoring</td>
</tr>
<tr>
<td>Bipolar</td>
<td>Track mood / Maintenance periods</td>
</tr>
<tr>
<td>Psychosis</td>
<td>Psychiatric collaboration</td>
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<tr>
<td>ODD</td>
<td>Differential Reinforcement</td>
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A Word about Executive Functioning...

Planning
Cognitive Shifting
Inhibition
Attention
Organizing
Emotional Regulation
Working Memory
Executive functions involve cognitively and behaviorally managing multiple pieces of information

Useful ABA Techniques
- Visual Supports
- Time Delay
- Task Analysis
- Scripting
- Social Narrative

❖ Routines are important for automation
❖ Generalization is key
❖ EF Deficits are often hidden, but may contribute to behavior problems
Elements of an ABA Assessment

- Developmental domains to be addressed
- Short term goals and targets marked for priority
- Prescription for ABA intensity
- Behavioral History
- Medical History
- Educational History
- Create a plan for collaboration
- Parent Training / Parent goals
- BIP
- Fade Plan
How can psychologists craft reports to support ABA Treatment Plan Development

- Specify all diagnostic criteria
- Documentation should support the position that therapy will achieve functional gains beyond those expected as a result of growth and maturation
- Know the payor requirements for an evaluation that will support qualification for ABA services
- Prioritize Recommendations
- Make Recommendations behaviorally specific
- Provide information about how ABA providers can collaborate
- Recognize that early treatment can depend on your report
THANK YOU FOR ALL YOUR WORK!