Residential Treatment of Serious Behavioral Disturbance in Autism Spectrum Disorder and Intellectual Disability

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KEYWORDS

- Autism • Intellectual disability • Serious behavioral disturbance
- Residential treatment

KEY POINTS

- The behaviors exhibited by children with autism spectrum disorder/intellectual disability and serious behavioral disturbance (SBD) can be extremely dangerous and complicated to treat.
- Philosophic trends toward "least restrictive" treatment choices have had the unintended effect of stigmatizing residential treatment facilities (RTFs) as an option of last resort.
- In many cases, specialized RTF services should be considered as the first choice of treatment to provide the level of treatment intensity necessary to ameliorate SBD.
- Effective contemporary models of residential treatment provide an evidence-based, comprehensive program model that engages families and community resources in treatment.
- RTF providers need to educate funders and legislators on the treatment benefits and cost effectiveness of specialized, intensive models.

INTRODUCTION

In addition to displaying the core symptoms of autism, many children with autism spectrum disorder (ASD)/intellectual disability (ID) may also present with serious behavioral disturbance (SBD). The behavioral presentation of SBD often manifests as overactivity, tantrums, aggression, and self-injurious behaviors.[1,2] Initial treatment

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efforts often begin with home-based and community-based treatment services. At present, residential treatment is often offered only as a last resort when home-based and community-based services fail.[3,4] Opponents of residential treatment often cite poor outcomes and isolation from family as primary reasons for its tarnished reputation.[5,6]

This article, however, challenges the idea that residential treatment for this population should be an option of last resort. Residential treatment facilities (RTFs) can offer many advantages, which include a multidisciplinary professional staff, a continuum of care, and a safe therapy and training space for families and discharge providers. These advantages, combined with the best evidence-based treatment, staff training, and staff supervision interventions can make an RTF the first and optimal choice for treatment. Contemporary proponents of residential treatment are answering critics through development of specialized and intensive models of treatment that show significant promise in ameliorating SBD in children with ASD/ID.

Case: Residential Treatment for Serious Behavioral Disturbance

"Sam" was an 11-year-old boy diagnosed with autism and moderate intellectual disability when he was admitted for residential treatment. Sam's parents reported that his history of physical aggression and self-injurious behaviors became increasingly more intense and frequent as he grew older. Sam had been enrolled in special education classes through his local public school, and was receiving home-bound instruction because of the severity of his behavior in the classroom. The family no longer felt safe taking Sam for trips in the community. Before admission for residential treatment, Sam had been hospitalized twice in a children's psychiatric inpatient unit. The family had received outpatient therapy services when Sam was younger and were receiving sporadic in-home therapy services at the time of evaluation for RTF services.

After admission for residential treatment, the treatment team began a multidisciplinary assessment and the process of identifying discharge service providers for linkage with the residential treatment team. Key assessments used in treatment planning for Sam were communication, functional behavior, and psychiatric. Using the assessment information, the team developed a comprehensive positive behavior support plan. Interventions included intensive functional communication training (including targeting functionally equivalent responses); antecedent modifications of the classroom and residence to support communication and instructional opportunities (including the use of visual supports); rich ratios of positive reinforcement to shape targeted responses; and consistent extinction and de-escalation procedures. Psychiatric medications were also adjusted to target the assessed mental health component of existing concerns. At the beginning of treatment, Sam had one-to-one direct staff support for implementation of his behavior support plan for 16 hours a day; the one-to-one approach was faded as treatment progressed. A clinician was also available in the classroom and residence to oversee staff training, and to monitor data collection, implementation integrity, and treatment plan modifications.

Furthermore, Sam's family was actively involved in his residential treatment. The family received training in all interventions outlined in the communication and positive behavior support plans. Training methods included assistance with environmental modifications in the home, shadowing of professional staff, watching video of their son's routines and interventions, and direct coaching (ie, modeling, guidance, and performance feedback). As a part of discharge planning, the residential treatment team also worked with identified community providers of wrap-around services, training them in the treatment protocols in a similar manner as was provided to the family. The residential team then collaborated with the wrap-around provider to begin Sam's transition back to the family home. Discharge was accomplished through a gradual introduction of Sam into his home and into community outings with his family. The residential team continued to provide both in-person support and clinical expertise to the family and wrap-around provider until Sam was fully integrated back home. Gradual reintroduction into the family home occurred at approximately 6 months into Sam's RTF stay, with fading of RTF services and support occurring during the next 6-month treatment period.