**TREATMENT OF PROBLEM BEHAVIOURS IN CHILDREN DIAGNOSED WITH ASD AND/OR ID**

**Jeffrey Esteves, Breana Morrell, Adrienne Perry**

**York University, Toronto, ON**

**Objective**: Despite evidence that formal behavioural interventions are most effective for the treatment of problem behaviour in children with developmental disabilities, a wide variety of both formal and informal treatment methods are used (Condillac, 1997; Feldman et al., 2004). The purpose of the current study is to examine how problem behaviours are being treated in Canadian children. Specifically, we will examine the prevalence of five treatment modalities (no treatment, medication, formal behavioural, informal behavioural, and non-behavioural [OT/PT, art therapy, special diet, etc.]) among children with aggressive and destructive behaviour (ADB) or self-injurious behaviour (SIB). We will also report on how treatment modality is associated with four child characteristics (age, sex, diagnosis, and adaptive level).

**Methods**: The current study is a secondary analysis of data collected as a part of the Great Outcomes for Kids Impacted by Severe Developmental Disabilities (GO4KIDDS) project. 372 parents completed the GO4KIDDS Basic Survey (Perry & Weiss, 2008). The children ranged from 4 to 20 years of age (*M* = 11.3), and had an Intellectual Disability (ID; *n* = 167) or both ASD and an ID (ASD+ID; *n* = 205).

**Results:** There was a high rate of both ADB (60%) and SIB (39%). Further, 31% of the sample displayed both ADB and SIB. Children with ASD+ID displayed a higher prevalence of both ADB and SIB than children with an ID alone.

For treating ADB, informal behavioural strategies were the most common intervention modality (59%), followed by non-behavioural interventions (38%, *n* = 79), and medication (34%, *n* = 70). Surprisingly, 13% (*n* = 26) of children received no treatment for ADB. Formal behavioural intervention was the least commonly reported intervention strategy (17%). Children with ASD+ID were, however, more likely to receive formal behaviour intervention than children with an ID alone (Χ2 [1] = 6.39, *p* = .011).

In terms of SIB, the most common treatment was informal behavioural strategies (51%), followed by non-behavioural treatments (38%), and then medication (33%). Again, a notable minority of children (18%) received no treatment for SIB and formal behavioural intervention was the least commonly reported intervention (19%). Children with ASD+ID were more likely to receive formal behaviour intervention than children with an ID alone (Χ2 [1] = 7.94, *p* = .005).

Logistic regression analyses are in progress to determine the predictive contribution of child sex, age, diagnosis and adaptive level, considered simultaneously, to the type of treatment the child receives.

**Discussion/Conclusions:** Overall, there is a high level of variability in the interventions which children with ASD+ID or ID alone receive. Despite the evidence providing support for formal behavioural intervention, it is the least commonly utilized intervention methodology to support children displaying ADB or SIB. Reliance on informal behavioural approaches is concerning given the safety risk these behaviours pose to the child and others. Clinical implications of these findings, and suggestions for future research will be presented.

**Correspondence**

Jeffrey Esteves, M.A. (ADS), M.A. (Psych.)

York University

4700 Keele Street

Toronto, Ontario, M3J 1P3

jesteves@yorku.ca

(416) 736-2100 ext. 40266

Breana Morrell, B.A.

York University

4700 Keele Street

Toronto, Ontario, M3J 1P3

bmorrell@yorku.ca

(416) 736-2100 ext. 40266

Adrienne Perry

York University

4700 Keele Street

Toronto, Ontario, M3J 1P3

perry@yorku.ca

(416) 736-2100 ext. 33765