Occupational therapy practice guidelines for autistic people across the lifespan.

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American Occupational Therapy Association, Inc. (AOTA)

Patten KK, Murthi K, Onwumere DD, et al. Occupational therapy practice guidelines for autistic people across the lifespan. Am J Occup Ther. 2024 May 1;78(3):7803397010. PubMed

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Overview

Guideline Objective

To support occupational therapy practitioners in providing interventions that promote subjective well-being among autistic people and their families through optimal engagement and participation in occupations

Patient Population

Autistic people and their families

Recommendations

Recommendation Statements

Improving Self-determination and Positive Mental Health

Self-determination

Self-advocacy Interventions

Practitioners could consider providing group or both group and individual self-advocacy interventions for autistic middle-school and college students to enhance self-advocacy skills, where autistic persons are expected to advocate for accommodations in an academic setting (45-min to 5-hr sessions, 1 to 5 days/wk, from 1 wk to 1 semester). (**B: Moderate**)

Interest-based Interventions

Practitioners could consider providing group, interest-based interventions, either with middle-school-age autistic students alone (with parents receiving parallel group sessions) or with nonautistic students as well, to improve knowledge of ASD and develop mastery and competence in areas of interest (1×/wk, 30 to 90 min, for 6 to 14 wk). (**B: Moderate**)

Mental Health

Cognitive Behavioral Therapy (CBT) Interventions

Practitioners should provide small-group (individual and/or family) CBT, when appropriate, to improve anxiety, social responsiveness, and expression of challenges and to decrease parental negative accommodation behaviors for autistic children, adolescents, and young adults (1 session/wk, 45 min to 3 hr, over 16 to 36 wk). (**A: Strong**)

Mindfulness-based Interventions

Practitioners could consider providing mindfulness-based stress reduction (MBSR) interventions (group training and home practice) to improve depression in autistic adults (group: 2 to 2.5 hr, 1×/wk, 8 to 9 wk, and 40 to 60 min 6 to 7 days/wk home practice). (**B: Moderate**)

PEERS Program

Practitioners could consider providing the PEERS® program to improve peer friendship and social skills and to decrease social anxiety and challenging behaviors for autistic youths and adolescents. (**B: Moderate**)

Clients Age ≤18 Yr: Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), Rest and Sleep, Work, Education, Play, Leisure, Social Participation, and Health Management

ADLs

Feeding Interventions

Practitioners could consider providing clinic-based parent-only or parent-child dyadic feeding interventions for autistic children age 2 to 8 yr to improve mealtime behaviors and food selectivity (10 to 11 sessions of 60 to 90 min each, over 12 to 20 wk, and 3 possible booster sessions over an additional 6 wk). (**B: Moderate**)

Education

Teacher-focused Interventions for Classroom Engagement

Practitioners could consider providing manualized, explicit teaching coaching interventions, through group and individual delivery, to teachers of kindergarten through 2nd grade, to improve classroom engagement related to social interactions for autistic students (teacher training: 3 days, 18 hr total for initial training, followed by 2 to 4 coaching sessions/mo for 8 mo; students received the intervention over the course of a school year). (**B: Moderate**)

Student-focused Interventions for Classroom Engagement

Practitioners could consider providing student-focused explicit teaching interventions to promote engagement in daily classroom routines for autistic students, age 4 to 10 yr or in Grades 3 to 5, through individual or group interactions, to improve goal behaviors or following directions, transitioning smoothly, and avoiding getting stuck (5 to 40-min sessions, either daily for 2 wk or through 28 lessons over the course of school year). (**B: Moderate**)

Play

School-based Play Interventions

Practitioners could consider providing school-based play interventions, individual and group, to increase engagement and encourage spontaneous and symbolic play for

autistic children ages 3 to 10 yr (1×/wk to 2×/day, 20 to 60-min sessions, ranging from 5 wk to over the course of a school year). (**B: Moderate**)

Clinic-based Peer-mediated Play Interventions

Practitioners could consider providing a clinic-based peer-mediated intervention with parent education to promote play in autistic children age 6 to 12 (1 hr, 1×/wk, 10 wk). (**B: Moderate**)

Clinic-based Interventions to Improve Play Performance

Practitioners could consider providing a clinic-based intervention, including peer modeling, video modeling, therapist modeling, and parent involvement to improve play performance for autistic children age 6 to 12 yr (1-hr session, 1×/wk for 10 wk). (**B: Moderate**)

Sleep

Parent Education Interventions

Practitioners could consider engaging parents (groups or individuals) in clinic-based parent sleep education interventions to enhance sleep participation (behavior, latency, and efficiency) for their autistic children age 2 to 21 yr (60 to 120-min sessions over 2 to 8 wk, weekly or biweekly, and potential follow-up support). (**B: Moderate**)

Social Participation

Clinic-based Interventions for School-age Autistic Children

Practitioners could consider providing clinic-based multifaceted approaches to supporting social participation among school-age autistic children, including increased socialization with peers, parent education, and supporting child self-regulation (45 to 90-min sessions, 1 to 5×/wk, some added follow-up booster sessions, and potentially 30 to 60-min sessions 1×/wk, 6 to 12 wk for parents). (**A: Strong**)

Web-based Social Interaction Interventions

Practitioners could consider providing self-guided or therapist-assisted web-based training for parents of autistic children, 18 to 73 mo, to increase the child's social participation (range = 6 1-hr sessions over 1 mo to 12 75-min sessions over 12 wk (with a potential of 2 30-min coaching sessions 1×/wk for 12 wk). (**B: Moderate**)

Paraprofessional Training Intervention

Practitioners could consider providing the Remaking Recess intervention for autistic students age 6 to 11 yr to support school paraprofessionals in providing students support on the playground to socialize, decrease solitary play, and identify friends (16 sessions, 10 to 60 min long, daily for 2 wk and consultation for 6 wk, or over 12 wk). (**B: Moderate**)

Interventions With Neurotypical Peers

Practitioners could consider providing group interventions using neurotypical peers to support social participation among autistic children (age 4 to 14 yr; 8 to 100 sessions, 15 to 60 min, over 8 to 20 wk). (**B: Moderate**)

Clinic-based Interventions for Autistic Children (Early Childhood)

Practitioners could consider providing group and individual, online or in person, clinic-based parent education to improve social participation among autistic children during early childhood (1 to 4×/wk, 60 to 120 min, over 6 to 20 wk). (**B: Moderate**)

Clinic-based Interventions for Adolescents

Practitioners could consider providing clinic-based group or group and individual interventions that allow autistic adolescents to socialize with neurotypical peers in order to provide education about social skills (1 90-min session/wk for 14 to 20 wk). (**B: Moderate**)

Person-centered, Student-centered, or Family-centered Planning Approaches

Mentoring Interventions for Autistic Adults (Age ≥18 Yr)

Practitioners could consider using mentoring programs (nonautistic or autistic mentors) with person-centered planning (PCP) components to improve knowledge, decrease symptom reports, develop self-selected goals, and increase empowerment and perceived social support, among other outcomes, in community-based and university settings (1 to 5 hr, 1×/day, 1 to 2×/wk, 5 days to 6 mo). (**B: Moderate**)

Multicomponent Structured Module Interventions With PCP Components for Autistic Adults (Age ≥18 Yr)

Practitioners could consider using multicomponent structured module interventions with PCP components, in university, community, or clinic settings, to improve social and self-

determination outcomes for transition-age autistic adults (1 to 2-hr sessions, 1×/wk, for 10 to 19 wk). (**B: Moderate**)

Coaching Interventions With Caregivers of Young Children on the Autism Spectrum

Practitioners could consider using coaching interventions (individual or group, in person or remote) with caregivers of autistic young children to improve individualized family or child goals and caregiver sense of competence, empowerment, or self-efficacy (45-min sessions, 1×/wk, for 10 to 12 wk). (**B: Moderate**)

Clients Age >18 Yr: Participation in ADLs, IADLs, Rest and Sleep, Work, Education, Play, Leisure, Social Participation, and Health Management

Work

Project SEARCH

Practitioners could consider providing Project SEARCH, a multicomponent, manualized intervention delivered in the context of the work site to improve acquisition of competitive employment for autistic adults (9 mo, involving 3 10 to 12-wk internship rotations, for 35 hr/wk). (**B: Moderate**)

Assistive Technology

Practitioners could consider providing a workplace intervention that includes strategies to support the individual needs of the individual combined with assistive technology (Apple iPod Touch applications) to improve employment skills and decrease job coaching support for autistic adults (individually tailored, 1-hr sessions over 12 wk, ranging from 7 to 16 hr total). (**B: Moderate**)

Social Participation

Peers

Practitioners could consider providing the PEERS for Young Adults intervention, in a community-based setting, to improve social skills for autistic young adults (90-min sessions, 1×/wk for 16 wk). (**B: Moderate**)

Manualized Social Skill and Participation-based Interventions

Practitioners could consider using manualized interventions to improve social communication and engagement within the context of social group activities for autistic adults (1.5 to 2-hr sessions, 1 to 2×/wk for 12 to 19 wk). (**B: Moderate**)

Evidence Rating Scheme

Levels of Evidence

Each article evaluated in the reviews was assigned a level of evidence using the Oxford Centre for Evidence-Based Medicine (2009) framework:

- **Level 1a**: Systematic review of homogeneous randomized controlled trials (RCTs) (e.g., similar population, intervention) with or without meta-analysis
- **Level 1b**: Well-designed individual RCT (not a pilot or feasibility study with a small sample size)
- **Level 2a**: Systematic review of cohort studies
- **Level 2b**: Individual prospective cohort study, low-quality RCT (e.g., <80% follow-up or low number of participants, pilot or feasibility study), ecological study, or two-group nonrandomized study
- **Level 3a**: Systematic review of case-control studies
- **Level 3b**: Individual retrospective case-control study, one-group nonrandomized pretest–posttest study, or cohort study
- **Level 4**: Case series (or low-quality cohort or case-control study)
- **Level 5**: Expert opinion without explicit critical appraisal

Strength of Evidence (Level of Certainty) Designations

Level	Description
Strong	• Two or more Level 1a or 1b studies

<table>
<tr><td></td><td>The available evidence usually includes consistent results from well-designed, well-conducted studies. The findings are strong, and they are unlikely to be called into question by the results of future studies.</td></tr>
<tr><td>Moderate</td><td>At least 1 Level 1a or 1b high-quality study or multiple moderate-quality studies (e.g., Level 2a or 2b, Level 3a or 3b)
The available evidence is sufficient to determine the effects on health outcomes, but confidence in the estimate is constrained by factors such as:
Number, size, or quality of individual studies, and
Inconsistency of findings across individual studies.
As more information (other research findings) becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion related to the usefulness of the intervention.</td></tr>
<tr><td>Low</td><td>Small number of low-level studies, flaws in the studies, and so on.
The available evidence is insufficient to assess effects on health and other outcomes of relevance to occupational therapy. Evidence is insufficient because of:
A limited number or size of studies,
Important flaws in study design or methods,
Inconsistency of findings across individual studies, and
Lack of information on important health outcomes.
More information may allow estimation of effects on health and other outcomes of relevance to occupational therapy.</td></tr>
</table>

Recommendation Rating Scheme

AOTA uses the grading methodology provided by the U.S. Preventive Services Task Force (USPSTF)* for clinical recommendations. For the purposes of these Practice Guidelines, AOTA reports only recommendations graded A, B, and D, the grades that best support clinical decision-making:

A: There is *strong evidence* that occupational therapy practitioners should routinely provide the intervention to eligible clients. Strong evidence was found that the intervention improves important outcomes and that benefits substantially outweigh harms.

B: There is *moderate evidence* that occupational therapy practitioners could routinely provide the intervention to eligible clients. There is high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial.

D: It is recommended that occupational therapy practitioners *not* provide the intervention to eligible clients. At least fair evidence was found that the intervention is ineffective or that harms outweigh benefits.

*Adapted from the *USPSTF Grade Definitions*.

Related Content

Supporting Documents

- Interventions That Foster Self-determination in Autistic Individuals (2013–2021); 2023 Mar 1.
- Interventions for Developing Positive Mental Health in Autistic Individuals (2013–2021); 2023 Mar 1.
- Interventions to Support Participation in Basic and Instrumental Activities of Daily Living for Autistic Children and Adolescents (2013–2021); 2023 Mar 1.
- Interventions to Support Participation in Education for Autistic Students (2013–2021); 2023 Mar 1.
- Interventions to Support Participation in Play for Autistic Children and Youth (Dates of Review: 2013–2021); 2023 Mar 1.

- Interventions to Support Participation in Sleep for Autistic Children and Adolescents (2013–2021); 2023 Mar 1.
- Clinic-Based Interventions to Support Social Participation for Autistic Children and Adolescents (2013–2021); 2023 Mar 1.
- Interventions to Support Social Participation for Autistic Children and Adolescents in Homes and Communities (2013–2021); 2023 Mar 1.
- Person-Centered Interventions for Autistic Adults Ages 18+ (2013–2021); 2023 Mar 1.
- Person-Centered Interventions for Autistic Adolescents Ages 13–19 Years (2013–2021); 2023 Mar 1.
- Family-Centered Interventions for Children on the Autism Spectrum (2013–2021); 2023 Mar 1.
- Interventions for Work/Employment Participation for Autistic Adults (2013–2020); 2023 Mar 1.
- Interventions for Social Participation for Autistic Adults (2013–2020); 2023 Mar 1.

Implementation Tools

- Occupational Therapy Practice Framework: Domain and Process - Fourth Edition; 2020 Aug.

Patient Education

No patient education materials available.

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ECRI's Guideline Profiles are designed to provide information and assist decision-making. Variations in practice will inevitably, and appropriately, occur when clinicians take into

account the needs and preferences of individual patients, available resources, and limitations unique to an institution or type of practice. Every healthcare professional using these Guideline Profiles is responsible for evaluating the appropriateness of applying them in a clinical setting.

TRUST Scorecard

Composition of Guideline Development Group (GDG)

Multidisciplinary GDG Members **Yes**

Methodologist Involvement **Yes**

Incorporation of Patient and Public Perspective

Systematic Review of Evidence

Literature Search

Study Selection

Evidence Synthesis

Foundations for Recommendations

Strength of Evidence Grade

Description of Benefits and Harms of Recommendations

Summary of Evidence Supporting Recommendations

Strength of Recommendations Rating

Clear Articulation of Recommendations

Funding Source **Yes**

Disclosure and Management of Financial Conflicts of Interests

External Review

Updating

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