Association University Centers on Disabilities
Webinar: Intersections Between Infant/Early Childhood Mental Health and Autism: Identification and Intervention
Wednesday, November 15, 2017
12:45 p.m. – 2:32 p.m.

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>> Sarah DeMaio: Hello and welcome to "Intersections Between Infant/Early Childhood Mental Health and Autism: Identification and Intervention," a joint webinar by AUCD's Autism And Mental Health Aspects Special Groups. I am Sarah DeMaio, program manager on AUCD's Child Technical Assistance Team. If you're interested in being kept up to date on other autism or other mental health related research, services, and activities within the AUCD network, I encourage you to sign up to be on the Special Interest Group listserv. AUCD has a range of Special Interest Groups each with their own listserv. I'm putting the link to join these groups in the chat box now.

I'd like to thank you all for joining us today. Before we start the webinar, I'd like to go over a few logistical details. Due to the number of participants, all participant lines will be on mute for the duration of the presentation. You can type in questions at any time into the chat box at the bottom of the screen.

Second, there will be a brief period for questions and answers at the end of the presentation. You can ask a question by entering it into the chat box or you can raise your hand using the button at the top of your screen. After you raise your hand, an AUCD staff will call your name and enable your microphone. Depending on the time available and the number of questions, we may not be able to get every question. We may need to combine questions for the presenters.

Finally, this webinar is being recorded and it will be archived in the AUCD webinar library at aucd.org/resources/webinarlibrary.

I'd like to introduce our presenters for today. Marian Williams is a licensed psychologist, Associate Professor of Clinical Pediatrics at the University of Southern California, and Co-Director of the Interdisciplinary Training at the USC University Center for Excellence in Developmental Disabilities at Children's Hospital in Los Angeles. She's a program area lead for the Early Childhood Mental Health Program at CHLA, directing infant families, mental health programs that provide assessment and interventions for more than 300 young children each year, an expert trainer for the 0 to 5, 0 to 3 [Inaudible] by the California Center for Infant Family and Early Childhood Mental Health as reflective practice [Inaudible].

Christine Raches, is a clinical psychologist, board certified behavioral analyst at the Riley Child Development Center LEND Program. She participates in an interdisciplinary team that conducts evaluations on children with suspected neurodevelopmental disabilities, behavioral disorders or developmental delays. She supervises graduate level trainees. Dr. Raches is also an early intervention specialist providing psychological evaluations and ongoing services in home and clinic-based settings. Dr. Raches is certified in the Early Start Denver Model, an intensive intervention for young children diagnosed with ASD.

We'll begin with a presentation by Dr. Marian Williams about "Assessment and Diagnosis of Autism Spectrum Disorder in Young Children."

>> Marian Williams: Hello and welcome to the webinar. I wanted to go over the objectives for the first part and then I'll be turning it over to Christine to talk about interventions. We're going to talk about how autism can be identified early, how autism may co-occur with other mental health concerns, and then I'll briefly present a model for interdisciplinary assessment of Autism Spectrum Disorder within the context of an infant mental health program that we have here at children's hospital.

So I'm putting on the screen some questions for you to consider and you will know the answers by the end of the talk if you don't already. So maybe jot down your guesses and then you can be testing yourself.

At what age are children with Autism Spectrum Disorder typically diagnosed? And contrast that with at what age did their parents typically have concerns about their child's development?

How young do you think that autism can reliably be diagnosed?

And what do you think are the most important early signs of autism in infants and toddlers?

And lastly, why should clinicians consider autism in a child younger than 2?

So I want to talk about one of the most important points I think today, to think about this window of early intervention for Autism Spectrum Disorder. So Christine will be talking more about intervention and will make the case that intervention works and that if we can change the trajectory for a young child very early, we have the hope of very good outcomes. But in fact, that window for early intervention is often missed. So parents typically had concerns by 12 to 18 months, those parents who later -- whose child later got a diagnosis of autism. However, there is a broad window in terms of the age of onset of full criteria for Autism Spectrum Disorder. So with some children showing the full symptoms as young as 14 months but others really not showing full criteria until 36 months. We know that the average age of diagnosis in this country at this time is between 3 and 4 years. That's progress from a few years ago but it's still much older than the time at which parents are starting to have concerns.

I wanted to draw your attention to this article published fairly recently on Autism Spectrum Disorder in early childhood. And in particular there's an excellent table that shows the symptoms in infants and toddlers and the symptoms in preschoolers with a lot of detailed example in terms of what you're looking for in the younger ages. There's been quite a bit of research to try to push toward an earlier identification of autism. I just want to briefly mention the types of research and how they're done, how we've been able to gather this information.

There originally were retrospective studies, so looking back with children who had received a diagnosis of autism and looking back -- the problem with that is memory. It's not as reliable as going forward. Those early retrospective studies also used videos of children's 1st birthdays which was an innovative and helpful approach. However, we all know that 1st

birthday parties are not a typical day in the life of a child, so there's some limits to that as well.

A challenge in doing prospective studies starting with infants and then going forward until they get diagnosed with autism is that most children obviously do not develop autism. So you would need a huge number of babies to study to find the links between the early symptoms and later autism. So the approach that is being used most often now is to follow high-risk infants who have a higher probability of developing autism. And one method of doing that is to follow infant siblings who have an older sibling who has been diagnosed with autism.

So that's -- most of the study that I'm going to mention used that approach. It's important to remember, though, that there might be some differences between children in those high-risk groups and children who were not in a high-risk group in terms of their autism symptom profile. So there's still work to be done on that.

Looking at all of these prospective studies following high-risk children, we have learned quite a bit about the age when children with autism can be reliably differentiated from children without autism. And one thing we know is that at 6 months we really cannot make the distinction. So there are no reliable group differences based on multiple studies at the age of 6 months.

There are some studies that suggest that some of the earliest signs might include a more difficult temperament, differences in eye tracking. So infants who gaze at the mouth instead of the eyes, for example, are more interested in look at geometric patterns rather than humans. However, there aren't really good behavior correlates to assess these things currently.

Also, there have been signs of motor delays and atypical motor development very early. By 12 months differences are definitely emerging in many children who later get diagnosed with autism. Parents may or may not perceive these more subtle changes but they include things like a decline in looking at faces, a decline in social smiling, and a decline in social responsiveness. And it's important to note that that change between 6 months, when I said you can't tell a difference, and 12 months, is that there's actually a decrease in social communication behaviors. So it's not that the babies just kind of reach a plateau and fail to progress. It's that they actually do less smiling, less look at faces over time. They also show less pointing and waving when compared to children who have other developmental disabilities or language delays so those kind of non-verbal communication strategies are a good way to distinguish autism from other types of developmental delays.

By 14 months there are some children that can be reliably diagnosed with full Autism Spectrum Disorder with diagnoses that then remain stable into the future but there are other children who don't meet criteria at this young age but they later show clear diagnosis of autism. So there's quite a range when we can be confident in the diagnosis.

By 24 months if there's a clinical diagnosis of autism by an expert clinician, those diagnoses are reliable and stable over time and that's been shown in a number of studies.

Then it's important to note that at 36 months there are many more children who get diagnosed who did not meet the full criteria at 24 months. So, again, we basically have this window from 14 months to 36 months where we need to be monitoring, assessing, and providing intervention while we're determining if the full diagnostic picture is present.

So what are some of the earliest signs to look for as a clinician or as a parent? These are some of the signs that reliably predict a later diagnosis of autism in a toddler. There's a reduction in initiating and responding to joint attention, less seeking of social interaction and showing anticipation such as when a parent comes in the room and the child

looks up with a bright face, anticipating being picked up. There's reduced eye contact, reduced response to their name being called, reduced babbling, reduced gestures, reduced imitation of other people's actions and sounds and facial expressions, and there's also less positive affect. And there are a few things increased in toddlers who later get a diagnosis of autism and those include an intense inspection of objects visually, repetitive actions with objects and tapping, and more negative affect. So these are some of the signs that should be red flags and lead to further assessment.

And then I would say if you had to just remember two symptoms that should lead to concern, because these are the ones that most clearly differentiate autism from other types of delays, those are joint attention, so that desire to share something of interest with another human by looking at the object, looking at the person, looking back at the object.

I have in my office a very colorful butterfly hanging from the ceiling that most children love. And I feel like one of the most important signs when a child walks in my office with their parent, they almost always notice the butterfly. And I'm noticing do they look back to see if their parent also noticed the butterfly. So even if they're not able to talk or point or use more sophisticated communication, just that shift of eye gaze tells me that it matters to them if they can share that lovely butterfly with another person versus just enjoying it for themselves.

And the second thing that distinguishes autism from other delays is affective expressiveness. So children with significant language delay, we still expect they will show a lot of facial expression and, in fact, maybe even more because they're compensating for the difficulty with language.

So once you've thought about these red flags, you're going to move toward, well, how do you actually diagnose the disorder. So the diagnostic criteria in DSM-5, I'm going to assume you're all somewhat familiar with. They focus on these two domains, the social communication and social interaction deficits. And then secondly this combination of restricted or repetitive patterns of behavior, interest, or activities. There are not separate criteria by age in DSM-5 so the same criteria are applied from infants to adults. In DSM-5, the symptoms need to be present during the early developmental period, which is defined somewhat loosely give something flexibility for the clinician. And the symptoms have to cause impairment.

So I wanted to bring your attention to the publication of DC:0-5. I'm sure many of you are familiar with 0-3 and 3R and this is latest edition. It's published by 0-3 and they are offering two-day trainings in the full diagnostic manual. So if you're interested in that kind of training, you would reach out to the 0-3 directly to find out when they're coming to your city.

I am one of the expert trainers for 0-3 in DC:0-5 and I have permission from them to use a few of their slides to give you a hint of how autism is addressed in this manual that's specifically developed for that birth to 5 age range.

This is the five axis system for DC:0-5. If you look on the right-hand side of your screen, if there was a diagnosis of Autism Spectrum Disorder, it would fall in that Axis I, clinical disorders. But I wanted to draw your attention to the range of domain that are covered in DC:0-5. The relational context between the parent and child, physical health conditions, psychosocial stressors, and the overall developmental competence in different domains. And the recommendation is that you consider all of those contextual factors before you come to a clinical diagnosis.

And within that Axis I this slide just shows you the different domains where there are diagnoses in DC:0-5. And then zeroing in on the neurodevelopmental disorders, this is the list of neurodevelopmental disorders which, of course, is where Autism Spectrum Disorder comes

into play.

So Autism Spectrum Disorder, this slide you will find familiar because those are the two domains of symptoms that I just mentioned are in the DSM-5.

So the DC:0-5 Autism Spectrum Disorder diagnosis is aligned with the DSM-5 and has very similar symptoms in terms of social communication and repetitive and restrictive behaviors. And with these symptoms causing impairment. So there's quite a bit of overlap there.

I think the difference is that when you look in DC:0-5, you will see descriptions of the symptoms that really fit with the age-group of much younger children which can be quite helpful if you're more familiar with the diagnosis in older children.

So again, the domains are similar. And just to give you a couple of examples of the symptoms specific to younger children, so reduced or limited ability to initiate joint attention to share interests or emotions or to seek information about objects of interest in the environment.

And then in DC:0-5, there is specifiers. If you make a diagnosis of Autism Spectrum Disorder, then you specify if there is also a global developmental delay, if there's also a language delay, if there's a known genetic condition, and if there are sensory processing abnormalities.

In DC:0-5, the youngest age that you can receive a diagnosis of Autism Spectrum Disorder is 18 months. And that's to be a bit conservative even though we know there are some children that we can diagnose younger, wanting to make sure it's very clear that they meet full criteria before giving that diagnosis.

Now, that being said, this is kind of a review of some of the things I've already mentioned but we know that there are some children who show very significant risk factors in terms of symptoms at 9 months and then even more at 12 months. So we really want a way to identify children who seem to be becoming symptomatic so that we could provide some intervention as early as possible to change that developmental trajectory and minimize the chance that they will go on to develop full Autism Spectrum Disorder or even if they are going to develop the full syndrome, to be able to improve the eventual outcome.

So DC:0-5 has put forward this new diagnosis that's called Early Atypical Autism Spectrum Disorder or EA-ASD for short. So this is designed to identify children who have symptoms that fit within the Autism Spectrum Disorder but they don't meet full criteria.
For Early Atypical ASD, the child must be younger than 33 months. They can't meet criteria for full Autism Spectrum Disorder. So in other words, it's not just a younger version of autism. If there's a child who, let's say, is 24 months but they clearly meet all the criteria for ASD, then would go ahead and make the diagnosis of ASD and not use this Early Atypical one.

And then the symptoms are basically the same as Autism Spectrum Disorder but the threshold is lower, so fewer symptoms are required in order to make the diagnosis. And I'll show you a little visual of that in a second. So you still have to have some social communication concerns and you still need some repetitive and restrictive behaviors. So the point is to identify children who are showing impairing early signs and symptoms but not yet meeting full criteria.

Here’s how that looks. If you want to compare full autism and then this early atypical autism in the social communication domain, for the early atypical, you need to have symptoms in two out of the three areas, whereas for full autism, you need deficits in all three of those social communication areas. And then for restricted and repetitive behaviors, similarly, you just need one of those to meet criteria for early ASD and you need two of them to meet full criteria

for autism.

So hopefully that gives you a taste of the new information in DC:0-5 but I really encourage you to take the full two-day training because obviously this is the tip of the iceberg.

So back to the beginning of the talk when we talked about this window for early intervention, the age when parents first express concerns about their child's development, these are children who are later going to get a diagnosis of autism, is 18 months, as I mentioned. The age when a definitive diagnosis is reached currently in this country is getting close to 4 years. And it's actually older than that for some groups of children such as Latino children, African American children, children living in poverty, children without health insurance. For all of those groups there is even a later diagnosis of autism, often not until kindergarten and yet we know this early intervention window is from birth to 3 years. So if we're not even getting a diagnosis until that window has closed, then we're missing that critical period.

One of the goals of this Early Atypical ASD diagnosis is to help clinicians reach that conclusion earlier, that there's at least enough evidence that the child should be provided with some intervention services that are specifically targeting those autism symptoms and not just, let's say, the language delay or the sensory needs that the child might be showing.

So moving along, I wanted to talk about the intersection of mental health disorders and Autism Spectrum Disorder. As we know, in a lot of states, certainly in California, we certainly have these two silos for funding, one more mental health services and a different one for developmental disabilities. Yet we know that for children these two domains overlap and are not -- and are intertwined and the children don't know that they are supposed to be getting funding differently for different things. They just come all in one package.

So we know -- most of the research on this has been done with older children where we know that 70% of children who have Autism Spectrum Disorder also have another mental health disorder and 41% have two or more mental health disorders. And fortunately DSM-5 has really made a big step forward compared to DSM-4 in terms of recognizing these dually diagnosed children who have, for example, in the ADHD category, the recognition that children can have both ADHD and Autism Spectrum Disorder. And they note that the same principle applies to concurrent diagnoses of autism with anxiety disorders, with depressive disorders, and with other comorbid diagnosis.

So it's the norm that if you see a child with autism, you should be looking for other mental health disorders as well. The most common co-occurring mental health disorders, and again, these are with school-aged and adolescents, anxiety disorders, ADHD, aggressive behaviors which might lead to a variety of diagnoses, and depression. So these are all things you should be on the lookout for if working with a child with autism.

Another domain to think about is experiences of trauma. So children who have developmental disabilities are likely to experience child abuse, sexual abuse, emotional abuse, neglect, and 30% are bullied by peers. So this is another area that you should be asking about and doing some detective work to identify trauma and then to think about treatment as incorporating a trauma informed approach.

Now, with young children there's very little research yet documenting co-occurring mental health symptoms and autism. But there was one study of toddlers who had Autism Spectrum Disorder and looked at other symptoms of mental health concerns besides the ones that are included in the autism diagnosis. And they found that there were higher rates of tantrums, inattention and impulsivity, anxiety, eating problems, and sleep problems. So this

pretty well parallels what we see in school-aged children and confirm that it's important to be looking holistically at all of the child's needs when you're assessing.

So many children with autism need mental health services but unfortunately most of them do not receive any. So they may get early intervention and they may get special education but it's not the norm that they get referred to a mental health professional.

So I wanted to just briefly talk to you about a program that we have at Children's Hospital Los Angeles in our UCEDD that's within our Early Mental Childhood Program. So we're kind of embedding services to both diagnose and treat autism within an early childhood mental health setting. So within that larger program we provide services for children ages birth to 5. And it's funded through a special mental health contract with our County's Department of Mental Health.

Now, because of the funding for mental health services in California, the treatment that we get paid for focuses on the co-occurring disorders and not the autism itself but what we found is that the county DMH has been quite open to recognizing the dual diagnoses that are so common and, therefore, allowing us to use our mental health dollars to provide treatment that's in a more holistic way and also to assess the needs of these children.

We get referrals from the Child Welfare System, from other hospitals, and our own hospital from preschools. We're obviously in an urban setting. And the majority of families that we work with are living in poverty and have Medicaid insurance. And 70% of the families that we serve are Latino with about half of those being monolingual Spanish speaking.

So just to focus on the assessment part of our program, we do assessments for children from birth to 5 years and we have interdisciplinary teams that include these four disciplines: developmental-behavioral pediatricians, occupational therapists, psychologists, and speech-language pathologists. And then we have trainees in each of those discipline who are learning to do these kinds of assessments.

And the most common referral questions for the assessment program are questions about a diagnosis of autism as well as other developmental disabilities. And often the kids have had differing opinions from previous assessments that they've been through and so the parents are confused about what is the accurate diagnosis. We also often work with children who have had medical traumatic stress. And there's a question about how that is impacting them in the present. And then many of the children have very complex referral questions that include a history of trauma, concerns about developmental delay, and concerns about mental health symptoms such as disregulated behavior, a depression, anxiety, etc.

And the approach that we take is based in a therapeutic assessment perspective. If you're not familiar with therapeutic assessment, I would really encourage you to read up on it. If you work in infant mental health, you'll find it very simpatico with your way of thinking. It was originally developed by Steve Finn and his colleague, Tonsager in the 1990s with adults but it since has been adapted for children.

There's an article that we wrote recently with some case studies applying the therapeutic assessment model to infant mental health. And Natalie Gart, one of our post post-Doctoral lows, was the lead author. The reference is in your reference list.

The basic approach here is that you're collaborating with the family in co-creating your assessment. It's not a sort of expert model. It's more of a collaborative model. The family is an active participant in the assessment. You're encouraging meaning making -- throughout all of the assessment sessions there's a goal of reducing the family's isolation and increasing their hope in terms of what their child will be able to do. And the actual assessment is

considered to be an intervention approach.

So, for example, we're helping the parents develop a narrative about their child and we're helping to shift the parents' story of their child to a greater understanding of what their child needs and what their child's strengths are. And often this has a healing impact on parents who have sometimes been through multiple assessments before they come to us and have a lot of feelings about how assessment happens.

So two of the goals for our therapeutic assessment approach are to enhance the parents' understanding of their child and also to strengthen the caregiver-child relationship through the course of the assessment. And we think this is especially important. When you think about children with early signs of Autism Spectrum Disorders, we know that obviously these developmental disabilities are first diagnosed in the early childhood period. So parents remember for life, you know, how they learned about their child's diagnosis and what that clinician who made the diagnosis, what they conveyed to the family in terms of their concern for that child but also their celebration of that child, the way that they are. So I think that taking a therapeutic approach really sets the stage for the family's growing relationship with their child, even in the context of the developmental challenges that they're having.

So to end, I'm going to show you just kind of the procedures that we use when one of the assessment questions is about autism and which discipline participants in that.

I should have mentioned that the interdisciplinary team, we share leadership so any one of the disciplines can be a lead on the case and also take leadership of our case conference so that we're trying to convey kind of an inegalitarian team approach. I think the families appreciate the fact that we are integrating the findings from all the different professional rather than expecting the family to try to integrate that on their own.

So we use the ADOS, the ADI-R routinely. We also do a cognitive assessment if it hasn't already been done. We assess adaptive behaviors. We have a speech language pathologist who assesses communication, language, and speech. We have an occupational therapy evaluation. And we're also always including some more informal observation of the parent-child play and the parent-child relationship. We do some assessment of social emotional functioning, always looking for those dual diagnoses, those other mental health needs that may not be obvious at first. We try whenever possible to observe the child in a natural setting, whether it's their preschool, their daycare, their home, maybe even the park. And then our developmental behavioral pediatrician does a physical exam and considers the impact of any medical conditions on the child's presenting symptoms.

We consult with the child's primary care physician. Often they are the one that referred the child and we want to try to loop back in terms of what their concerns are, their perspective on the child's difficulties. And then close the loop so that they hold the information that we gather from the assessment. And then the input from all of these different sources is integrated into one report.

Lastly, I just want to talk about the efforts that we make to have a family-centered and culturally appropriate approach to our assessment. We consider the families to be key team members. We invite all the primary caregivers to participate and we will go to great lengths to make that possible for them in terms of scheduling and reaching out individually to those that live at home or are even doing a home visit for those who can't come in.

Whenever possible, we pair Spanish-speaking families with Spanish-speaking clinicians. We're really fortunate that we have I think 70% of our early childhood staff and trainees are fluent in Spanish. We also work with children who speak many other languages.

And for most of those we need to use interpreters but we're very intentional in terms of our efforts to prepare interpreters not just for the content of what we're going to talk about but even to prep them in terms of the pacing of a session, the importance of allowing pauses, allowing the parent time to process what we're talking about before moving on with the content.

We work on delivering linguistically appropriate assessment in terms of the selection of measures and the way they're administered. We give families detailed feedback and as much time as they need to process that feedback. We translate reports into the parents' preferred language. And then we provide follow-up through the process of getting linked with additional services whether it's with us or through the developmental disabilities symstem or through the school system or all of those.

So I think that's it. I provided some key references, not everything that I talked about but a lot of them. And I did want to alert you this autism navigator site. It has an excellent course called -- I think it's something like autism and toddlers or identifying autism and toddlers, something like that, that's free and has lots of nice videos and other materials to help you understand more about what autism looks like in young children.

And now I'd like to turn it over to Christine.

>> Christine Raches: Can you hear me ok? Can you hear me ok?

>> Marian Williams: Yes.

>> Christine Raches: Sorry. I'm a little bit paranoid because I'm in a tiny office.

I am going to wrap up our time together by talking about just some very select treatments that we probably want to consider when we are diagnosing Autism Spectrum Disorder in very young children. So when I chose the treatments that I was going to present and share with you today, I really focused in that birth to 5 age. And, of course, we just had Marian provide a very nice presentation about how early we can diagnose, so keep that in mind for you as well as we move through some of these slides together.

A couple of very basic objectives that I want you guys to get out of today. I want you to know what evidence-based practice is. And I want you to have an awareness of what some of those evidence-based treatments are. We are going to talk about ABA intervention. And two of the treatment modalities are based in ABA principles which is helpful and useful. And I'm going to introduce the concept of mental health and how that can be helpful in working with parent-child relationships when we have children who are either at risk for Autism Spectrum Disorder or who have been diagnosed with an Autism Spectrum Disorder. And as we move through the treatment slides, you'll notice that every single treatment is based in this idea of a parent-child relationship. And I think as we consider early childhood development and how learning occurs, that that inclusion of parents is so very important.

I already said this. I have a tendency to do that sometimes. So we are going to introduce a couple of different therapy modalities. We're going to talk about infant mental health and then I'm going to introduce you guys to the Early Start Denver Model and also Floortime.

And full disclosure. I know it was said in my biography but I am a certified Early Start Denver Model therapist so that is where my knowledge and basis comes from. I also really appreciate Floortime and the similarities. So we'll talk about that as well.

As we get started, I think that as we live and practice in a world where the need for treatment for Autism Spectrum Disorders is so large, I think it's always important to consider evidence-based practice and just revisit what it means to have a treatment modality be shown to be evidence-based. So this slide is really just on here as a reminder for us. So when we are

making recommendations or helping families navigate the system to find what's available to them locally, we really want them looking in the empirically validated research.

So in order to be evidence-based practice, we need at least randomized or quasi-experimental design studies, at least two separate ones. Or you can have five single-subject design studies and if you have those, then that's qualifies a treatment modality as being evidence-based or some combination of that.

I think as we move through these next couple of slides, keeping that in mind and helping families understand that process is really helpful, particularly given the world of the internet where families are doing their own research and they're finding things on their own. So helping them understand that is very important.

We need to choose evidence-based practice because what we're doing matters. And when we're recommending or connecting families for treatment, we have to help them understand that currently there is no cure for Autism Spectrum Disorder. So what we're really doing is we are helping them connect to therapy that are going to help manage the core symptoms and build skills that are now currently a deficit for that particular child. So when we talk to families being very transparent that this therapy modality is not going to be a cure but really we're working to build some of those core deficits -- or some of those core skills and fill some of those core deficits.

We always want families to be suspicious of anything that claims of a cure or a quick fix. And in the world of the internet, families are reading personal testimonies all of the time. So, again, helping them understand and go back to what does the research show us, what does the evidence show us. I think perhaps the biggest reasons for us as professionals is that we need to guide families towards evidence-based practice. We don't ever want to do anything for our families that is going to cause harm to them either financially, emotionally on physically. So those are the reasons why we're really going to stress evidence-based practices.

Families have a lot of options and there's a lot of things out there. In my practice, one of the things that I'm often asked about is how I do decide what's important in the scheme of my particular child. So keeping in mind that families may need to put together more of an interdisciplinary, multi-disciplinary treatment for their child and that could include behavioral programs that could include medication management, that could include educational programs or other interventions. But, again, keeping that center focus on that we're not connecting them with treatments to cure Autism Spectrum Disorder. We're connecting them with treatments to build skills and minimize some of those deficits that the children are presenting with.

When we looked at the research and when we look at what has traditionally worked in the treatment of autism spectrum disorders, there's a couple of core concepts that come up. So this slide highlights some of those for you guys.

We want to get children into treatment as early as possible. We know that early intervention works. Marian was talking about that desire and the need to move a diagnosis to an earlier age accurately and that that's important because we want to get those services started as soon as possible. Ideally we would love children to be in intensive interventions. We're looking at full-day programming for a full year, looking at greater than 25 hours per week. And, again, that's ideally. Because we know that not everybody has access to that. There are other barriers in place.

When we're looking at autism spectrum disorders, we want it to be directed administrations, direct therapy. We want it to be one-on-one if possible with the inclusion of small group instruction. And, again, particularly when we're working with these very young

children what we're thinking about is helping them transition into a traditional school setting or traditional peer environments and so the small group instruction is very important.

Everything should be systematically planned and developmentally appropriate. We want it to be measurable. We want to be able to take data and show that the intervention that we're doing are the reason for the improvement in that child.

It should be individualized. And likely I am preaching to the choir here but intervention should be geared towards that particular child's age, their developmental needs, the families' needs, and the individual child's strengths and weaknesses. And Marian, when she talked about some of those assessment measures, those are good starting points for us in understanding what the child's skills are and where we want to go from there, all while keeping in mind that autism intervention and treatment is not a precursor to like a gifted and talented program

. So we are keeping children within the developmental expectations for their age. If it's consistent with their educational goals, we would love to get them around typically developing peers. And part of that is when we're working with young children diagnosed with Autism Spectrum Disorder, we are really thinking about that generalization and maintenance and skills. And that should be at the forefront of every discussion, at the very start of therapy. How do we generalize what we're teaching them and then how do we maintain that over time and getting them into settings with typically developing peers can be an excellent strategy for that as well.

And then finally, and this one is the one that is so very important to me as a psychologist and behavior analyst, it's the inclusion of parents as interventionists. I continue to be shocked at the number of parents who are really uninvolved in their child's treatment. They're either dropping them off and picking them up or the treatment is happening at school and there's little inclusion of the parents.

So the treatment strategies we're talking about today are really parent-child focused. And I want that to stay at the heart of our discussion because every person working with the child, regardless of diagnosis, should be working themselves out of a job. And that includes teaching the parents to do the things that you're doing so that we can continue to have progress even when we aren't directly working with that child.

These are the evidence-based treatments that are currently out there as of 2014. So it's a little bit dated but it was still the best representation that I could come up with. What I encourage you do is do what you're doing today and that's participant in webinars, read the research, and really stay up to date with what's coming out because we are getting some very exciting research pretty regularly that's supporting us and leading us to different types of evidence-based treatments.

So I offer this to you as a resource for you of what some of those evidence-based treatments are. One that's very important to me as a psychologist and behavior analyst is that concept of reinforcement. So the strategies we're going to talk about today are all very reinforcement based. We know that we can teach skills at a very rapid rate with the use of reinforcement. So helping families identify reinforcement strategies that work is very important.

This next slide, we had a discussion about whether or not we should remove it but I left it in there because this is what's important to me. This slide is the 10 most commonly used interventions by parents. So I think it's important to always be aware of what parents are using and what's out there and available to parents. And not all of these are evidence-based practices so I think having conversations with families, what's available, what are you

accessing, what are you reading about, and then tying it back into, well, here's what the research says about these programs and here are some programs that may meet your goals in a much more effective and research-based manner. So just keep that in mind that these are what parents are reporting they're trying.

The first over-arching strategy and intervention that we're going talk about is ABA, Applied Behavior Analysis. So just a reminder that Applied Behavior Analysis is the process of a systematically applying interventions based on the principles of learning theory and what we're working to do is improve socially significant behaviors to a meaningful degree. And then the final part of that is proving that those interventions are responsible for that improvement in behavior.

So that's what we're kind of focusing on. And two of our strategies that we're going to talk about are based in ABA. ABA has a lot of years of research evidence, supporting it, which is lovely. And I give you some of those websites so that you can go find some additional research and learn a little bit more about that if you're interested.

This is my favorite slide of when I'm doing training because I think it's a nice reminder that Applied Behavior Analysis is not just for Autism Spectrum Disorders and that's the conversation we're having today, which is fine. But I like to remind families and I like to remind professionals that we can use these strategies for other diagnosis and I think this becomes an important part of advocacy. Because there is research supporting the use of ABA for a variety of diagnoses and a variety of medical disorders. So keeping that in mind I think is very helpful.

I also like to jokingly say that my husband does not have a diagnosis and is a typically developing male and he has benefited from the strategies used in ABA. It's out there. It's available. We know it works.

The goals of ABA are pretty broad but I think they really help us focus on the treatment and what we're working towards with families. So if you have a child who is seeking treatment for Autism Spectrum Disorder, one of the things we're going to be working towards is replacing problem behaviors. So we're doing that by teaching alternative, more appropriate behaviors.

Another thing we're doing is changing responses to behaviors. When we examine the function of behaviors or understand why behaviors continue to occur, we're often looking at the consequences so we're helping families, providers and professionals, understand and change their responses to behaviors as a way to minimize or increase a socially appropriate behavior. And so that third goal is increasing those social behaviors.

ABA can improve cognitive and academic skills. It is data-driven with a focus on understanding how children learn best. And as we understand and identify those skills, they can absolutely be generalized into a more educational setting.

Obviously we're also promoting learning readiness and helping them develop those skills needed for academic and social success, thinking outside of a traditional classroom but learning occurs in all contexts and so we're teaching and working with children to develop those learning readiness skills so that they can continue to learn as they continue to develop.

And then perhaps our large goal is that we want to maintain and generalize those skills. So it's wonderful if a child can do something for Miss Christine or Miss Jenny but they need to be able to do that skill and demonstrate that skill across all settings and across all different interactions so that's that generalization piece of that. And the maintenance piece is going back and following children post treatment, understanding that they are able to continue

to demonstrate that skill for us.

There are several different approaches to ABA and several different ways that ABA looks. What we're going to focus on is that last square in this hierarchy today. And it's not necessarily a hierarchy but in the structure. And we're really going to focus on those relationship and developmental approaches because, again, we're focused on the young children who have been diagnosed with Autism Spectrum Disorder or who were thought to be at risk.

The first therapy intervention that I want to introduce you guys to, and I'm being very aware of our time here, is the Early Start Denver Model. Again, as I said, I am a certified therapist. I hope it comes across that I am passionate about this therapy modality but I think it's important and we definitely want knowledge out there surrounding it.

So the Early Start Denver Model was developed by Sallie Rogers and Geraldine Dawson. If you look at the date of initiation, it's a relative new therapy, developed in 2010. That was kind of when it became known. But it's an evidence-based intervention specifically developed for very young children whose been diagnosed with autism or who are thought to be at a higher risk for being diagnosed with autism. It was developed for use with children as young as 1 year of age. And it can continue up until their 5th birthday. So focusing in on that early childhood period for us. It's a play-based intervention. It uses both behavioral and developmental principles into an integrated approach.

One of things that I very much like about this approach is that play-based focus comes across so clearly in your interactions with children and so while we're advocating for several hours of therapy a day, it's really several hours of play a day which can be helpful for parents and other providers to understand as well. It's really relationship-based focused. And it's based on the principles of ABA. And so if you were to review and learn more about the Early Start Denver Model, it is really focused on positive and negative reinforcements. So really focusing on reinforcement and getting the child motivated and learning new skills.

It's meant to be done naturalistically. So we want to be able to do it in a variety of settings. And, in fact, there's research to support these, the Early Start Denver Model, in parent homes, in daycare settings and childcare settings as well as in clinic settings. So there's a wide breath of where we are able to do it and there's evidence for it as well in the youth in the community. It's sensitive to those normal developmental sequences.

So if you've ever listened to Sallie Rogers speak or Geraldine Dawson speak, they talk about helping children resume that developmental trajectory that their same-age developing peers are on. So if we can identify it early and identify some of those deficits, then we can get them back into that normal developmental sequence.

There's significant parent parental involvement in this treatment modality which is exciting for me. Parents are involved in every therapy session. And then the expectation is that parents are learning these skills and then they are going home and doing therapy as well, as well as collecting some data and sharing that back. So parents really become a part of that treatment team, really focus interpersonal exchange and positive affect as well as the shared enjoyment of joined activities.

If you're interested, I have some short videos that I can share with you that are found in the Austism Speaks website that really shows what a therapy session looks like but it really is a very social, reciprocal interaction that occurs even with a very young child. And language and communication are taught throughout the treatment modality and the treatment intervention.

The Early Start -- I already said some of this. But what it aims to do is reduce the symptoms of autism and target all developmental areas. There's a really nice interview with Sallie Rogers in which she says if you identify a child at 18 months of age who has a language delay and then you want to focus on treatment for language, they're not outside of that developmental trajectory yet. All 18 months to 2-year-olds are learning to talk. And so really focused on what are the skill sets children should have and then how do we get them so that they're progression at that same rate as their peers.

I kind of already talked about this so I'm not going to repeat this slide. But it's here because, again, I just really believe the importance of this. You can see that I've bolded the deep parental involvement. And doing the ESDM myself, I think it's been one of the most rewarding experiences, watching parents evolve as caregivers and watching them develop some of those positive affects and interpersonal exchanges with their children.

The goals of the Early Start Denver Model are to bring children back into the social loop. And we could that by teaching the building blocks of social life. So these six blocks that are shared here below are the things that we should be thinking about in every interaction we have with the child. So if you were to consider, for example, meal time with a child, how would you teach imitation and emotion and communication? And how do you share experiences and engage in social and symbolic play and then engage in language development?

And the Early Start Denver Model works with families and helps them understand how they can take these regular everyday activities with their children and turn them into these really nice learning opportunities.

The second approach that we're going to talk about is Floortime. So shifting gears a little bit but not really. Admittedly I am not an expert in Floortime but, again, it's another programming that I'm very excited about because, again, it focuses on that parent-child relationship and it focuses on teaching very important social skills through a play-based intervention.

So it was developed -- it derived from the developmental individual difference relationship-based model or DIR, which you may have heard of. It was developed by Stanley Greenspan and Serena Weider. D stands for developmental, I stands for individual differences, and R stands for relationship-based.

So if you think back to the slide that I had that focused on what we wanted to see in Autism Spectrum Disorder treatment interventions, we wanted it to be developmentally focused. We wanted it to be individualized. And we want it to be relationship-based. And so Floortime meets that premise.

What Floortime does is it believes that we can help children expand their circles of communication by meeting them where they are developmentally and building on their strengths as children. Floortime was really meant to be intensive. And, again, they're advocating for two to five hours of intensive therapy day, getting up to 10 to 20 hours of therapy a day with the idea that families are going to take these skills home and they are going to continue to practice and utilize those strategies within their own relationships.

The DIR Floortime was developed as a way to help families, parents, and educators connect and teach skills to young children. It focuses, again, on those social positives, social, emotional, and intellectual capacities rather than on isolated skills and behaviors. So again, really looking at the child as a whole child and focused on really helping them meet some of those developmental needs.

One of the key differences between that Early Start Denver Model and Floortime is

Floortime can start as early as birth and can continue through adulthood whereas the Early Start Denver Model, really the curriculum kind of caps around the age of 5. Again, because it's based in Applied Behavioral Analysis strategies, data, it's focused on the Autism Spectrum Disorders that has evidence to suggest it can be used with a variety of different diagnoses.

I have a colleague locally who is a certified Floortime therapist and she has had great success in using it with children who have been diagnosed with disruptive behaviors. Again, a strong focus on caregivers and families and then unit leading that support system. It's really a very nice, key way that we can understand our children and each other and it builds connections, understanding love, communication, and engagement.

For me, these two approaches are very appealing because of the focus on those positive relationships. And I know that I've said that several times. But my own clinical experience is that oftentimes families are resorting to discipline and punishment and so just changing that dynamic when they're dealing with very difficult behaviors can be very eye-opening and kind of reengage and motivate families to participate again.

If you want to learn more, that is where you can learn more. I did quite a bit of research on Floortime and reached out to my friend. They're a little protective of their therapy modality which is fine but there is some way that you can learn more about that.

Again, Floortime aims to reach the six developmental milestones and I think that they're very similar to the Early Start Denver Model. But we are going to work on emotional and intellectual growth through self-regulation and developing interests in the world. We're working on intimacy and engagement in human relationships. We're working on two-way communication as well as complex communication. And then we're working on the development of emotional ideas as well as emotional thinking.

And then these are some of the key components or the keys to Floortime. Again, that strong focus on parent-child involvement. We're coaching the parents on engagement play and communication. We are -- in the Floortime modality they're really focused on finding small opportunities of time throughout your day to utilize these strategies. So again, keeping that generalization and that maintenance of skills occurring as we go throughout a typical day with a child.

We follow the child's lead and we meet the child where they are. There's an excellent example of a description of a therapy session in which the child is repetitively tapping the block and so the parent goes over and repetitively taps the block with the child. And then the child looks up at the mother and then now we have a connection. And we're going to keep building on that connections. So we can include those strong areas of interest and we can include scripting. And, again, really helping them progress across that developmental sequence that they're working towards.

I feel like I've pretty much said all of this. But I like that last point and I think it's worth saying again. When we're dealing with behaviors, we're treating all behaviors as form of communication. And Floortime is very aware of that and cognizant of that. And so they are always understanding that communication -- or that behaviors are trying to tell you something and so helping parents identify that and helping parents explore what they might be trying to tell you.

Switching gears just a little bit. I wanted to introduce you guys to Infant Mental Health. The reason that I wanted to do that is because at least here in Indiana, where I'm based, when we're working with very young children who are at risk for autism spectrum disorders or who are in our Part C or early intervention programming, we don't have a ton of

access to ABA strategies and the Early Start Denver Model and Floortime. So I get a lot of questions from my early childhood providers and my daycare providers, healthcare providers, who want to know kind of what the framework that they can operate within and what something they can do to help families as they're helping them wait for an appointment to possibly get a diagnosis or as they're waiting for a more traditional approach.

So, again, as we kind of wrap up our conversation with the focus on parent-child relationships, I think this strategy fits nicely and it can be absolutely something that we can fall back on and utilize as one of our treatments -- interventions.

The Infant And Early Childhood Mental Health or Infant Mental Health, the focus is on directing the provider's attention to the well-being of all infants and toddlers within the context of secure and nurturing relationships. So again, really focus on the idea that development occurs within relationships. And at least for very young children that primary relationship is that parent-child relationship.

This is 0-3's kind of traditional definition of Infant Mental Health and if you have any knowledge of Infant Mental Health, you likely run across this definition. But I offer it here because I think there's a couple of key components that I want to highlight.

When we're focused on infant mental health, we are focused on the child's developing capacity. So that concept of developing I think is really important here. These aren't skills we expect the child to have mastered but it's a developing capacity. We're helping them and exploring their ability to form close and secure interpersonal relationships. We're helping them experience, regulate, and express emotions. We're helping them explore the environment and learn. And all of it occurs within the context of family community and cultural expectations. So looking at that whole child and really look at relationships and the idea of meeting the child where the child is at and helping them progress so that developing capacity.

It's synonymous with healthy, social and emotional development. And this slide was really put in there because we get pushback when we start talking about infant mental health. Mental health has a negative stigma, a negative stereotype and connotation to it. So we can talk about healthy social emotional development. And we're talking about the same thing.

When we talk about early childhood, infant mental health interventions, there's a variety of interventions out there. My plan was never to go into detail about them. But I want you guys to know that they exist and they're out there. So I think when we talk about infant mental health or mental health in general, there's a preconceived notion it involves laying on a couch or it tends to do with emotional disregulation. So when we're talking about infant mental health, not every child is going to need to see a therapist, as you guys know. But there's benefit that can come out of that relationship as well.

So when we're focusing on infant mental health, we can -- practice promoting well-being, preventing risk, and we're helping to maintain that relationship. So the way that I think this relation to Autism Spectrum Disorder and the treatment of that, within that parent-child relationship is we're still focused on helping this parent-child relationship and making sure it's a positive relationship and one in which they can learn and grow together. And infant mental health practices and interventions really does a nice job of promoting that. And promoting the well-being of that child within that context of that relationships really focuses on adaptive behavior and exploring the idea of change.

So again, I think as we consider Autism Spectrum Disorders and we consider that parent-child relationship, that this is big. Parents and providers really want to consider the possibility of change and growth that we know is possible. And we want to do it within the

context of a relationship with some self-regulation and understanding that external events are going to happen and they're going to influence us. So how can we come together and kind of work through some of those issues?

And understanding the impact of early years to development across the lifespan. We have a variety of people here today that I'm sure believe nearly intervention and they understand the importance of early intervention and understanding that it works. And infant mental health takes that into consideration as well and sees it as a very important part of development but understanding we're setting the framework for future development as well as future goals. So keeping that within our frame of mind.

And if we can start the child off within the context of a positive relationship and intervene as early as possible to teach some of those skilled deficits that we're identifying, we're really setting that child up for future success.

Within the context of infant mental health, we use some of these components to treatment. Again, I think they parallel very nicely, the relationships that we're talking about in the Early Start Denver Model as well as in Floortime. So we talk about the parallel process and we talk about the variety of relationships that occur within a therapeutic relationship. You have the parent-child relationship. You have the parent-therapist relationship. You have the child-therapist relationship. And then ideally you also have the therapist-supervision or mentor relationship. So there's a lot of relationships occurring in every single one of those impacting another relationship within that context. So we definitely want to keep that into our frame of mind.

We're focused on relationship, as I've said several times. Really that parent-child relationship is where our attention is. Very strength-based, again, falling into a nice parallel I think with the Early Start Denver Model and Floortime as we're focused on reinforcement and identifying what's working within the family and helping that.

And then this component of reflective practice which I know we haven't talked about but stepping back and reflecting on the relationship and reflecting on the strategies and things that you're suggesting or guiding with the family can be really very important. It should be a key component in your work.

And then giving adequate balance to the parent and child needs. So I think sometimes when we're working with young children either at risk with ASD or diagnosed with ASD our focus quickly becomes on the child. So infant mental health is a really nice reminder that the parent also has needs within that relationship. So making sure that we're also paying attention and giving some time to that parent and their individual needs as well.

The why dyadic? This is so very important and crosses across the three different treatment modalities we've talked about. Young children are not developing within isolation. They're developing within the context of relationships. And their well-being and their ability to progress and be successful in treatment is often tied to the emotional status of their caregiver. So we know and the research shows us that when we include caregivers in treatment, our interventions are more effective.

And, again, particularly with young children with ASD, we're not with them all the time. So teaching skills and teaching strategies that families can then utilize in their interactions when the therapist is not present I think is very important.

These are just, again, some of those typical components that we're going to talk about. The one I want to highlight because I'm very much aware of time and want you to have the opportunity to ask questions, but there's two to highlight.

The first is coaching around effective responses so all of the treatment modalities we've talked about have apparent coaching or modeling component to them. And I think that keeping that in mind and that giving constructive criticism and reinforcement in a manner that allows the parent in that relationship to continue to grow is really important. So parents are doing something and there's a more effective way, then we definitely want to coach surrounding that and parental attendance and participation are key. So really taking the time there in the beginning and developing rapport and developing a relationship with the parent so that they continue to value therapy and keep that as an important component of their child's treatment I think is really key to what we're doing here.

Some of the goals, again, I think they flow nicely with our Autism Spectrum Disorder treatments and what we've kind of always talked about. Ideally we want parents to increase their reflective capacity. We want them to be able to respond to the child's needs, not by immediately responding and reacting but really thinking about what is the child trying to communicate to me, what is the child trying to tell me.

We want to improve that parent-child relationship particularly when we have children who have social deficits. That's something to always keep in the forefront of our mind. More effective parenting skills. Let's teach families to move away from punishment and work more on reinforcement strategies to get the type of responses and behaviors that they're wanting from their child.

Some of the infant mental health strategies are focused on a reduction in trauma symptoms. So that's obviously something that would be a goal in infant mental health work and then always improving child behavior and teaching more appropriate replacement behaviors for the child.

These are some of the therapy modalities that are really based in infant mental health work. I'm not going to focus on those today but I put them up here because I know some of you don't have a lot of experience with infant mental health work and so having the ability to specifically research other treatment modalities if that's something that we're interested in is very important. So that's there if that's something you're interested in. I'm happy to connect with you and help you find some additional research -- or reading for you to do.

And so at that point, I think that I'm ready to entertain some questions and help you guys in any way that I can.

>> Sarah DeMaio: Thank you very much, Dr. Raches and Dr. Williams.

As a reminder for anyone on the webinar, you can submit questions in two different methods. You can click the raised hand icon. We will unmute your line and you're welcome to ask aloud.

I see we have a number of questions in the chat box so I will give a summary of the questions that have been already asked. The PowerPoint on the website, and the link is in the chat box.

And there was another question that looks like it's been answered as far as Early Start Denver Model training where those are accessible. There was a follow-up question to that as far as who is eligible to be trained. Clinical social worker, psychologist, specific discipline or more broadly inclusive?

>> Christine Raches: I can go ahead and answer that one. The Early Start Denver Model was meant to be an interdisciplinary treatment modality and so there aren't any regulations, per se, on who can be trained to do the Early Start Denver Model. It was geared towards social workers and psychologists and speech language pathologists, occupational therapists and

physical therapists with the belief being we're going to learn from each other and work together on a team to best treat the child.

>> Sarah DeMaio: Thank you.

We just had a question around parent involvement in daycare settings. How would you address that?

>> Christine Raches: I can take a stab at it and then let Marian chime in as well if she has additional input.

What may have to happen is in the daycare setting your focus is more on that child-caregiver relationship within the childcare setting. But if you are only providing treatment within a childcare setting, you have to consider ways to get the parent involved. Maybe that's an early morning session just prior to drop-off or have an evening session at pickup time so that we can keep the family involved.

If we're specifically thinking about the Early Start Denver Model, we wouldn't want all of our therapy time to be happening in a daycare childcare setting because of that generalization component. And so working with the family to find a time when they are available to be involved would have to be really important.

>> Sarah DeMaio: And then a specific question for Marian. Would you share some of the specific tools that your evaluation team uses.

>> Marian Williams: Sure. I put some of them on the slides toward the end.

For autism, specifically, we always use the autism diagnostic observation scale. And then we sometimes add the autism diagnostic interview. In terms of cognitive assessment, I've actually written an article with a couple of colleagues. It's listed in the references, the one that's William, Sando and Soles and it reviews basically all the cognitive tests available for 2 and 3-year-olds and it goes through especially their utility with non-verbal children or children who speak a language other than English. And it kind of talks about the pros and cons of the different measures. So that's a good source for the range of cognitive assessment tools.

For adaptive behavior, I like to use the Vineland. And it's just come out in the third edition. It's parent interview style. And I often find that actually talking with parents about adaptive functioning and going through specific skills really helps set up discussions about recommendations because they start to see, like, oh, these are the skills that my child is doing and these are kind of a next level of skills that they might be getting ready for and so I can refer back to that when we talk about adaptive strategies.

Let's see. For communication and language, I would say the one we use the most is the preschool language scale. But also our speech language pathologist. One of the things I love to do is have our speech pathologist observe our ADOS and then pull a language sample from that and then perhaps supplement that with her own interactions with the child or observations of the parent-child interaction. And that's a nice way to get a really naturalistic language sample.

Our occupational therapists use a variety of tools. I would be worried if I tried to capture them that I would say them wrong because I'm not an FT but I can certainly connect you with our OT department. I know they do like the MFUND which is more motor skills, the sensory process questionnaire a lot, and then we also have an OT gym where they go and do interactive activities and observe the child's responses. So that's my best approach.

And then we also often get parent questionnaires for more broad social emotional functioning. I especially like the BASC, Behavior Assessment System for Children, which has both parent and teacher, starts at 18 months, and I think nicely covers like the full range of

behaviors that you might be concerned about.

And then for younger children 12 months and up there's the Infant Toddler Social Emotional Assessment, and then for those little ones in the birth to 12-month range there's not a lot out there but sometimes we'll use the ASQ, social emotional or the social emotional scale that's part of the Bailey. So there's a very rapid answer to your question.

>> Sarah DeMaio: Thank you.

And there was another question that was around connecting [Indiscernible]. I believe it was typed in, giving the overview of the Early Atypical ASD assessment of how does that assessment [Inaudible]

>> Marian Williams: The -- it's helpful for assessing -- there's now the toddler module which goes down to the 12-month level. And I find probably the most useful tool in terms of really learning what you're looking for, you know, what do those social communication behaviors look like, what kind of restricted interest look like and to really hone your clinical skills in terms of capturing that.

The other thing I like about using it for young children is the parents in the room. So you're scoring not just the child's interactions with the therapist but also with their parent and you're getting to see them in those more natural interactions and not just a formal testing situation.

And then also I find when we're giving feedback to the parent, they were there for the ADOS so when you're describing say a certain symptom of autism, you can refined them where you got -- remind them where you got that from and it's transparent. It's more like remember when your child did this. Well, this is why that made us think about autism. We can kind of integrate the parents' experience of things that they observed.

>> Sarah DeMaio: Thank you.

I guess a question that could be answered by either of you is whether you have opinions about children who have been diagnosed with autism and then after early intervention [Inaudible] What is your experience with misdiagnosis versus child learning skills?

>> Marian Williams: I'm not sure I totally understand the question. I don't know if Elysa is still here and wants to say it out loud or I can try to guess.

Let me just say I have seen children -- ok. When I was in graduate school, which was a zillion years ago, I was basically taught if a child had autism it was hopeless. They weren't going to get better. They were going to have terrible outcomes. So that was the training that I got way back in the day. And what I know now, having worked with children with autism very closely and watched them over time, is that that's not the case and that I used to think if a child got drastically better, maybe they were misdiagnosed but I've seen kids where I feel like the diagnosis in very early toddlerhood was accurate and I'm confident in it. And then I see that child make tremendous progress even to the point where sometimes they don't meet the criteria for the disorder.

ow, obviously that's not all children. There's many who continue to struggle and don't respond as completely but it's led me to not be so suspicious now if I hear there was an early diagnosis and then the child makes tremendous progress. I believe that is possible, especially when it starts young. But I'm not sure if that's exactly what you were asking.

Ok. The yes. Ok. Thank you.

>> Sarah DeMaio: Thank you.

One final question. They just started an autism clinic at her agency. She says we're using an interdisciplinary team approach. We have now run into the issue capacity for

providing services to the children identified with ASD. Any recommendations on how to address it?
>> Marian Williams: Christine, that's the million dollar question.
>> Christine Raches: That's what I was going to say. Unfortunately I don't have this amazing recommendation except just to know that you're not alone. At least here in Indiana almost all of our autism treatment centers are operating on wait lists. So really doing some advocacy and helping at the state level and helping providers and insurance companies maybe expand what they're willing to cover but you're not alone.
>> Marian Williams: Yeah. And I think the Affordable Care Act is supposed to now, you know, require insurance companies to cover autism treatment, behavioral treatment. And I just think it's really important that we keep advocating that behavioral treatment doesn't specifically mean ABA, that it means, you know, it should include a range of approaches such as the ones that Christine was talking about and that those should be available so that you can kind of match the treatment to the needs of that individual child. But I think there's a lot of work to be done in terms of really having the number of well-trained providers to meet that need.
>> Sarah DeMaio: Thank you both, Marian and Christine, for sharing your experience and your expertise on this critical issue.

I'd like to thank all of those who attended for joining us this afternoon or morning, depending on where you are. I'd like to remind everyone that this webinar will be archived and available on the AUCD website. If you'd like to share it with others in your state or region.

This is a project funded by the [Indiscernible], AUCD's Technical Assistance to the network and our webinars on autism and mental health for people with intellectual and developmental disabilities are funded by Maternal and Child Healthcare. So we thank them for their resource and support.

At the end of the webinar we encourage you to take a few moments to complete the survey which will be -- which will pop up at the end of the webinar today. Your feedback will ensure that we continue to be able to provide high-quality programming relevant to you and your work.

Have a wonderful rest of your day.