Services for children and young people with ASD require a core investment. For example, for families and home based support and help is needed. Jointly commissioned and funded children’s resources consequences. These services should be funded using joint budgets to ensure good quality intensity work using a variety of professionals may be needed at different stages in the child’s development.

**Intervention recommendations (Grade C unless otherwise specified)**

- A co-ordinated care plan should be produced within 6 weeks of the MAA.
- A trained professional in ASD in each local area should be available. Be or must be capable of setting up a comprehensive home and pre-school based ASD specific intervention program within 6 weeks of any diagnosis.
- The recommendations is for access to 15 hours per week for each pre-school child (Grade A). Every local area should have an ASD trained teacher with resource backing who can visit any school and advise and guide on appropriate development and not be limited to single intervention training.
- All these three levels of ASD training should be evaluated and audited by the local area co-ordinating group.

- The key service must be identified for follow up and rapid referral to the full range of appropriate services recognizing that need change over time.
- A care manager should be identified for longer term co-ordination of the Care Plan for all complex situations.

**Resources (Grade C)**

Services for children and young people with ASD require a core investment. For example, for a multi-ethnic inner city local area population diagnostic assessment rates for some children per year have been quoted at £210,000 annually as for June 2002. Ongoing review, support and training for all professionals working in assessment and provision of services is an expert NIASA Working Group recommendation; an asterisk (*) indicates key points for clinical audit, which should be the responsibility of the local area co-ordinating group.

**Strategic planning (Grade C)**

- A local area ASD co-ordinating group should be established. In its responsibilities should include strategic planning and the patient informed development; audit and evaluation; local area training for parents, carers and professionals; academic and training links to inform local practice.

- Grades 1 to 5 are at least one randomised trial
- Grades 2 and 3 are at least one randomised controlled trial with a smaller sample size
- Grades 4 and 5 are at least one randomised controlled trial with a very small sample size

(See Recommendation 4.1 for justification of all proposed timeframes and details)

**Executive summary**

These guidelines address identification, assessment, diagnosis and access to early interventions for pre-school and primary school age children with autism spectrum disorders (ASD). It is hoped that they will encourage transparent, efficient diagnostic processes able to meet the needs of these children and their families. These guidelines are not presentable to the management of local area co-ordinating group.

**Identification**

Grade A requires at least one randomised trial Grade B requires well conducted clinical trials but no randomised clinical trials

Grade B requires wel conducted clinical trials but no randomised clinical trials

Grade C is an expert NIASA Working Group recommendation

An asterisk (*) indicates key points for clinical audit, which should be the responsibility of the local area co-ordinating group.

**Evidence**

The Royal College of Paediatrics and Child Health (RCPCH)

The guidelines have been published under the banner of The National Autistic Society (NAS) in collaboration with the Royal College of Paediatrics and Child Health and the Royal College of Psychiatrists.

The guidelines are for parents for all who work with children. They were developed by a multi-disciplinary core group of professionals from Health, Education, Social Services, parent representatives and representatives from the voluntary sector.

In the executive summary (and in line with the Royal College of Paediatrics and Child Health recommendations for accepted Grades of Evidence) all recommendations are graded as follows:

- Grades 1 to 5 are at least one randomised trial
- Grades 2 and 3 are at least one randomised controlled trial with a smaller sample size
- Grades 4 and 5 are at least one randomised controlled trial with a very small sample size

(See Recommendation 4.1 for justification of all proposed timeframes and details)

**National Autism Plan for Children (NAPC)**

The numbers of children with ASD who do not have a learning difficulty may have been previously underestimated.

There is evidence that higher functioning ASD is increasingly recognised (Chakrabarti and Fombonne, 2001).

1. The benefits of the early identification of ASD are recognised by parents and professionals alike.
2. While there is no easy to administer test for the universal screening of pre-school children for ASD, the identification of ASD is never straightforward, the recognition of alarming signals to identify these children for further assessment is needed.
3. There should also be a positive response to parental concerns at all times.
4. It is hoped that these guidelines will encourage transparent, efficient diagnostic processes able to meet the needs of these children and their families.
5. The guidelines are for parents for all who work with children. They were developed by a multi-disciplinary core group of professionals from Health, Education, Social Services, parent representatives and representatives from the voluntary sector.

**Executive summary**

Identification

- Grades 1 to 5 are at least one randomised trial
- Grades 2 and 3 are at least one randomised controlled trial with a smaller sample size
- Grades 4 and 5 are at least one randomised controlled trial with a very small sample size

(See Recommendation 4.1 for justification of all proposed timeframes and details)

**National Autism Plan for Children (NAPC)**

The Royal College of Paediatrics and Child Health (RCPCH)

The guidelines have been published under the banner of The National Autistic Society (NAS) in collaboration with the Royal College of Paediatrics and Child Health and the Royal College of Psychiatrists.

The guidelines are for parents for all who work with children. They were developed by a multi-disciplinary core group of professionals from Health, Education, Social Services, parent representatives and representatives from the voluntary sector.

In the executive summary (and in line with the Royal College of Paediatrics and Child Health recommendations for accepted Grades of Evidence) all recommendations are graded as follows: National Autism Plan for Children (NAPC)
As ASD is a developmental disorder the presentation will vary with age and sex, in any one individual, very over time. The characteristics of ASD may be more prominent at some ages than others. Thus a clear understanding of normal social, behavioral and language development is required among parents, carers and professionals at all ages of the developmental process. One child may be unaffected by other developmental syndromes including developmental co-ordination disorders and specific developmental disorders and medical conditions such as early epilepsy and tuberous sclerosis. Learning and psychiatric co-morbidities are common.

Identification recommendations

• No whole population screening test for autism (Grade B).
• Training of all involved professionals in the ‘telling’ signs of possible ASD at both pre-school and school age (Grade C).* • Regular opportunities (at least at 8-12 months, 2-3 years and 4-5 years) to discuss a child’s development with parents as part of ‘surveillance’ to detect and respond rapidly to any developmental concerns (Grade C).
• Age of detection/diagnosis of all developmental problems including autism/ASD as a specified developmental concern should be from birth and not be deferred until the next routine surveillance check.

Assessment

Stage 1 - a general multi-disciplinary developmental assessment (GDA) as for any child with a possible developmental problem. It should comprise the clear identification of concerns, a communication assessment should be made and speech and language competences assessed where needed by a speech and language therapist with ASD training.

Stage 2 - the assessment process is a multi-agency assessment (MAA). A similar approach will be locally appropriate, but for children with a possible ASD, it should offer all the components of the multi-agency assessment (MAA). In some cases stages 1 and 2 may coincide.

Stage 3 - the multi-agency assessment should be capable of assessing the differential diagnosis of possible ASD and providing a baseline assessment of skills and difficulties for both the child and the family.

Essential components for a complete multi-agency assessment (MAA)

1 Existing information from all settings should be gathered.
2 A specific ASD developmental and family history should be taken. No evidence exists on which to recommend any particular formulation, but this history should be taken by an experienced team member who is trained in ASD.
3 A semi-structured interview such as the Autism Diagnostic Interview (ADI-R) or the Diagnostic Interview for Social and Communication Disorders (DISCO) if the person taking the developmental history is not medically trained, then the medical history and examination should be completed separately.
4 Full physical examination should be taken across more than one setting. This could include tests such as the Autism Diagnostic Observation Schedule (ADOS). The focus of the assessment of primary school aged children should include their functioning in an educational setting.

A communication assessment should be made and speech and language competences assessed where needed by a speech and language therapist with ASD training.

An assessment should be performed in an appropriate setting by either a clinical or an educational psychologist with ASD training.

A cognitive assessment should be performed in an appropriate setting by either a clinical or an educational psychologist with ASD training.

Evidence of co-morbid medical conditions such as epilepsy should be sought but tests such as EEG not undertaken unless clinically appropriate. The evidence base for all investigations should be reviewed in the light of new evidence.

Stage 1 - a general multi-disciplinary developmental assessment (GDA) as for any child with a possible developmental problem. It should comprise the clear identification of concerns, a communication assessment should be made and speech and language competences assessed where needed by a speech and language therapist with ASD training.

Stage 2 - of the assessment process is a multi-agency assessment (MAA). A similar approach will be locally appropriate, but for children with a possible ASD, it should offer all the components of the multi-agency assessment (MAA).

Stage 3 - the multi-agency assessment should be capable of assessing the differential diagnosis of possible ASD and providing a baseline assessment of skills and difficulties for both the child and the family.

Essential components for a complete multi-agency assessment (MAA)

1 Existing information from all settings should be gathered.
2 A specific ASD developmental and family history should be taken. No evidence exists on which to recommend any particular formulation, but this history should be taken by an experienced team member who is trained in ASD.
3 A semi-structured interview such as the Autism Diagnostic Interview (ADI-R) or the Diagnostic Interview for Social and Communication Disorders (DISCO) if the person taking the developmental history is not medically trained, then the medical history and examination should be completed separately.
4 Full physical examination should be taken across more than one setting. This could include tests such as the Autism Diagnostic Observation Schedule (ADOS). The focus of the assessment of primary school aged children should include their functioning in an educational setting.

A communication assessment should be made and speech and language competences assessed where needed by a speech and language therapist with ASD training.

An assessment should be performed in an appropriate setting by either a clinical or an educational psychologist with ASD training.

A cognitive assessment should be performed in an appropriate setting by either a clinical or an educational psychologist with ASD training.

Evidence of co-morbid medical conditions such as epilepsy should be sought but tests such as EEG not undertaken unless clinically appropriate. The evidence base for all investigations should be reviewed in the light of new evidence.

Stage 1 - a general multi-disciplinary developmental assessment (GDA) as for any child with a possible developmental problem. It should comprise the clear identification of concerns, a communication assessment should be made and speech and language competences assessed where needed by a speech and language therapist with ASD training.

Stage 2 - of the assessment process is a multi-agency assessment (MAA). A similar approach will be locally appropriate, but for children with a possible ASD, it should offer all the components of the multi-agency assessment (MAA).

Stage 3 - the multi-agency assessment should be capable of assessing the differential diagnosis of possible ASD and providing a baseline assessment of skills and difficulties for both the child and the family.

Essential components for a complete multi-agency assessment (MAA)

1 Existing information from all settings should be gathered.
2 A specific ASD developmental and family history should be taken. No evidence exists on which to recommend any particular formulation, but this history should be taken by an experienced team member who is trained in ASD.
3 A semi-structured interview such as the Autism Diagnostic Interview (ADI-R) or the Diagnostic Interview for Social and Communication Disorders (DISCO) if the person taking the developmental history is not medically trained, then the medical history and examination should be completed separately.
4 Full physical examination should be taken across more than one setting. This could include tests such as the Autism Diagnostic Observation Schedule (ADOS). The focus of the assessment of primary school aged children should include their functioning in an educational setting.

A communication assessment should be made and speech and language competences assessed where needed by a speech and language therapist with ASD training.

An assessment should be performed in an appropriate setting by either a clinical or an educational psychologist with ASD training.

A cognitive assessment should be performed in an appropriate setting by either a clinical or an educational psychologist with ASD training.

Evidence of co-morbid medical conditions such as epilepsy should be sought but tests such as EEG not undertaken unless clinically appropriate. The evidence base for all investigations should be reviewed in the light of new evidence.