AUTISM NEWS

of Orange County & the Rest of the World

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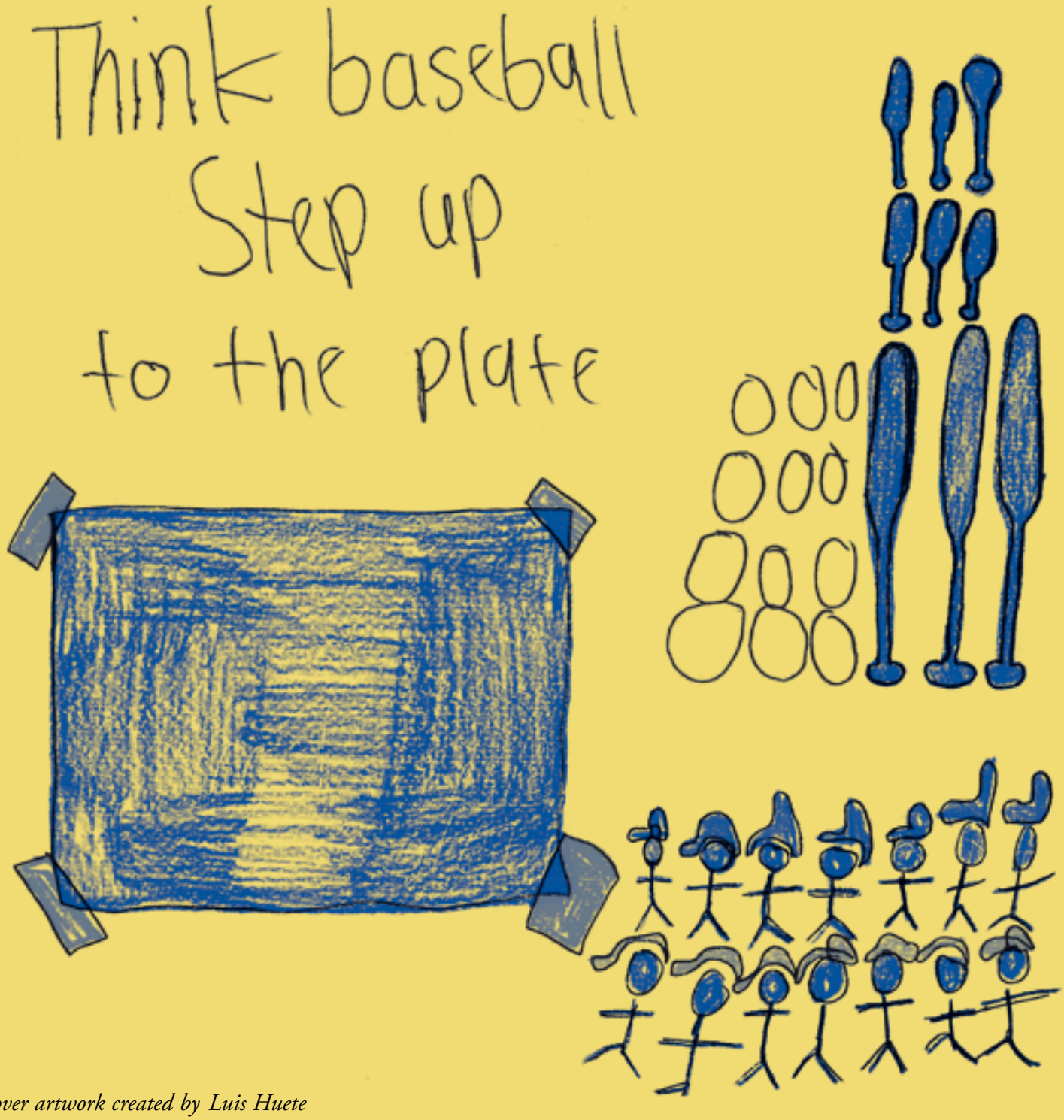

Cover artwork created by Luis Huete

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COVER FEATURE

We are pleased to feature one of our local artists, **Luis Huete**. Read more about Luis on page 11.

Mission Statement

Autism News of Orange County *& the Rest of the World* is a collaborative publication for parents and professionals dedicated to sharing research-based strategies, innovative educational approaches, best practices and experiences in the area of autism.

Submission Policy

The Autism News of Orange County–*RW* is available free of charge. The opinions expressed in the newsletter do not necessarily represent the official view of the agencies involved.

Contributions from teachers, therapists, researchers and relatives/children of/with autism are welcome. The editors select articles and make necessary changes.

Please submit articles in Microsoft Word using font size 12, double spaced, and no more than four pages in length (2600 words). Photos are encouraged and when submitted with articles the permission to include is assumed.

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Please visit our website: www.autismnewsoc.org

Editorial

By Vera Bernard-Opitz

The Many Sides of Assessment in Autism Spectrum Disorders

With the increased attention to Autism Spectrum Disorders (ASD), assessment has become one of the recent "hot topics." Over the last years the picture of autism has changed and with it the need to adjust existing assessment tools and to develop new assessment methods. Instead of focusing mainly on non-verbal children and adolescents with severe cognitive impairments, efforts of researchers and practitioners currently center on infants and young children on one side and individuals with high IQ and language skills on the other side. *For this expanded spectrum of individuals traditional assessment methods are usually not sensitive enough.* They fail to detect autistic tendencies in children and older individuals, who formerly might have been called "shy," "precocious," "unusual" or "quirky" and might have received another diagnostic label or no diagnosis at all. The above trend has led to a refinement of assessment tools as well as to the tendency to look for more naturalistic methods. Critical voices have pointed out that the diagnostic net might sometimes be cast too wide, leading to unjustified concern in parents of typical infants and young children and stigmatization/labeling individuals who just represent the wonderful variability of personalities we call the "human race."

Main functions of assessments:
- Diagnosis
- Normalize behavior
- Optimize learning
- Plan individual programs
- Provide access to services

The main functions of assessments are to find an appropriate diagnosis, to normalize behavior, optimize learning, plan individual programs and – last but not least – to provide access to services. One question is "What is expected for a particular individual at that age, in a specific situation and a specific cultural context?" This is important for the diagnosis of very young children, but also for older individuals, who never before might even have been considered for a diagnosis. *While former testing centered on developmental norms, general deficits and challenging behavior, in recent years developmental profiles, strengths of the individual and environmental support options have become the focus of assessment as well as the basis for intervention.*

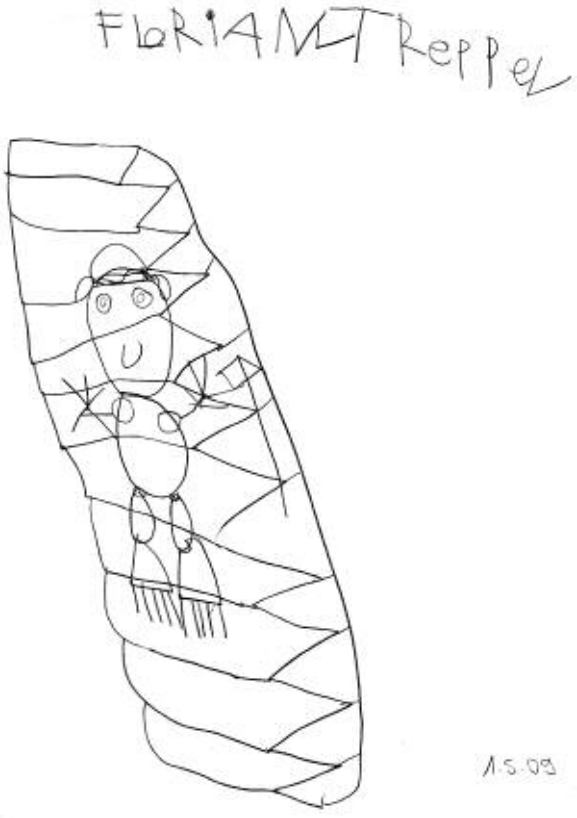
In this issue we highlight some of the new research findings on diagnosing children below the age of three years as well as contributions for young children and older individuals with different skill levels.

- **Carrie Allison and Simon Baron-Cohen**, Professor, both of Cambridge University, describe the challenges and benefits of screening for autism in children as young as 18 months. The encouraging results of their Q-Chat testing raises the question of whether this instrument can provide valid findings for wide-scale population studies and whether the specific score at a young age can predict outcome at a later age.
- **Michelle Garcia Winner and Pamela J. Crooke** attempt to assess the social mind in individuals with autism, looking at dynamic assessment options. They stress the importance of social perspective taking skills, not only on school-, but life-success, thereby going beyond autism and raising an important aspect for education in general.
- **Rachael Gray** summarizes some relevant norm-referenced speech-language assessments and combines these with structured interview scales with parents, and observations in natural settings. Her article reminds us that a comprehensive assessment is only possible when different members of the child's team collaborate.
- **Barbara Bloomfield** has been a frequent highlight of workshops organized by the S.U.C.S.E.S.S. program. She outlines core visual supports and predictors for the success of various support systems.
- **S. Michael Chapman,** Director of Supported Employment at the Division TEACCH, shares the TEACCH Transition Assessment Profile

Learning from children with ASD:
Social perspective taking skills, not only predict school-, but life-success, thereby going beyond autism and raising an important aspect for education in general.

(TTAP), which is a successful assessment tool for older children, adolescents and adults with ASD. This assessment, which reaches across multiple environments, together with the array of visual supports, demonstrate the functionality of an assessment instrument, which is directly related to effective transition programs and positive long-term outcomes.

- **Andrea Walker,** S.U.C.S.E.S.S. Project Coordinator, from the Orange County Department of Education, introduces the Assessment Focus Academy, a five-year-effort within Orange County which has successfully provided training and support for preschool to secondary school staff involved in educational assessment for students with ASD.
- Our parent section has many highlights, such as the moving account by **Zane's mother** on the different stages of accepting his diagnosis and finding support from caring and loving teachers.
- Also from Singapore is a photo we will remember for a long time: a child with autism helping another child face a challenging new situation. "Let's do it together" – thanks to **Salwanizah**, Head of the Early Intervention program, of the Autistic Association Singapore for this contribution and all the support for children like **"Jack" and "Jill"!** Again the message "Let's do it together" is one we can apply beyond this context!
- Last but not least: Our cordial congratulations go to **Luis Huete** and his teacher **Lauren Myers**. Our cover artist won the prize in a competition kindly organized by **Christina McReynolds**, to help the *Autism News* survive the current financial crisis by illustrating the theme *"Step up to the Plate."*



This picture of a staircase was drawn by ***Florian Musolff*** *as an image of stepping up and getting better every day.*

After six years of ANOC-*RW*, this is the first issue which is only available on our website. The budget crisis has significantly impacted our sponsors, and we need the support of the community to continue. In a recent survey of more than 100 readers we received very enthusiastic feedback. We are very honored. We also very much appreciate the support of parents and colleagues who have "Stepped up to the Plate" and hope that many other readers will join them.

Please spread the news that ANOC needs help and pass on our brochure. ***We hope that with the support of the community we can continue an "invaluable publication that successfully bridges the all too formidable gap between academic research and everyday practice" (a comment from one of our readers).***

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Screening for Autism in Toddlers: A Revised Measure

By Carrie Allison & Simon Baron-Cohen

Autism is a lifelong Pervasive Developmental Disorder (PDD) that is characterized by qualitative impairments in social interaction and communication, along with repetitive and stereotyped behaviors and/or interests. Autism is one of several conditions that represent variations in the manifestation of impairments, including Asperger Syndrome (AS), atypical autism and PDD not otherwise specified (PDD-NOS). Autism is behaviorally defined, although the etiology may be genetic, neurobiological (Bailey et al., 1995; Bolton et al., 1994), and/or neuroanatomical (e.g., Courchesne, Carper & Akshoomoff, 2003) in origin. There is no clear unifying pathology at the genetic level (Geschwind, 2008). The prevalence of autism has been estimated to be as high as affecting 116 per 10,000 individuals, or 1 in 86 (Baird et al., 2006).

Traditionally, autism was conceptualized as a distinct categorical condition defined by behavioral impairments. Unlike other developmental conditions such as Down syndrome where there is a clear genetic etiology, there is no biological marker that determines the presence of autism. Increasingly, autistic features have been proposed to be on a continuum (Baron-Cohen, Wheelwright, Skinner, Martin & Clubley, 2001; Constantino & Todd, 2003; Wing, 1988), with autism representing the upper extreme of a constellation of traits that may be continuously distributed. This has shifted thinking about autism away from a discrete categorical approach, towards a more dimensional and quantitative approach.

The diagnosis of autism is often delayed because it can be difficult to detect in very young children. Parents often raise concerns about their child by about 18 months (Wing, 1997) but there is usually a significant delay between the point of first concern and an eventual diagnosis. In a large survey of parents of children with a diagnosis of an autism spectrum condition, Howlin & Asgharian (1999) found that abnormal social development was most commonly reported as the main area of concern. In parents of children with autism, this concern was usually noted by 18 months, but later for parents of children with AS (a milder form of autism) - at around 30 months. In a UK longitudinal study, the average age at diagnosis ranged from 45 months in children whose diagnosis was autism, to 116 months in children with a diagnosis of Asperger Syndrome (Williams, Thomas, Sidebotham & Emond, 2008).

The benefits of early detection and diagnosis of autism could be several. First, early detection may allow the child to benefit from the implementation of specific interventions, leading to a better overall outcome for the child (Harris & Handleman, 2000). Evidence that demonstrates that early (versus late) intervention improves outcome is currently lacking, although Lord, Wagner, Rogers, Szatmari, Aman, Charman et al (2005) reports that studies do exist which show significant improvements in outcome for children with autism if intervention starts early (McEachin, Smith & Lovaas, 1993; National Research Council, 2001; Sheinkopf & Siegel, 1998).

Autism Research Centre
Cambridge University

The ARC at Cambridge University collaborates intensively with outside researchers. As part of their research various tests have been devised. Some of these tests are made available for download.

Tests can be downloaded if they are used for genuine research purposes, and due acknowledgement of ARC as the source is given.

Please visit the following website for further information:
http://www.autismresearchcentre.com/tests/default.asp

Lower functioning children may respond better and make measurable gains in IQ if intervention is implemented before the age of four. Second, early detection is important for parents so they can avoid lengthy delays between initial concerns and eventual diagnosis. This may allow them to start learning to manage their child's often difficult behavior. The stress that is sometimes involved in having a child with autism can have consequences for other family members so the sooner the difficulties are recognized, the better (Hastings et al., 2005). Third, early diagnosis may lead to the prevention of secondary difficulties associated with autism, such as anxiety (Tonge, Brereton, Gray & Einfield, 1999), depression, or the prevention of bullying (Howlin, 2000). Fourth, **in the UK** the economic impact of individuals with autism has been estimated to be high. For children, **the aggregate national costs of supporting children with autism are estimated to be £2.7 billion each year, and for adults this amounts to £25 billion each year.** For both adults and children, the majority of this cost is due to services required for support (e.g., residential care for very low functioning individuals) (Knapp, Romeo & Beecham, 2007). It is hoped that earlier diagnosis will allow for earlier implementation of interventions. In turn, this may lead to reduced impairment and ultimately reduce the economic consequences, nationally.

The many benefits to early diagnosis provide the motivation to attempt to improve on current identification and diagnostic practice through screening for autism, with the ultimate aim of leading to earlier prognostic benefit. It is important therefore to identify individuals with autism as soon as possible in order to maximize the support to both the child and their family. In the UK, there is no standardized routine developmental screening for autism (Mawle & Griffiths, 2005) despite a wealth of available screening tools. In contrast to the UK policy, the American Academy of Pediatrics (Council on Children With Disabilities, 2006) recommends that all children receive screening for autism at 18 and 30 months. In the US, there is clearly a different perception about the potential benefits of early detection of autism.

Attempts to screen children as early as 18 months of age for autism have provided mixed results. The first attempt took place in the early 1990's in the United Kingdom by Simon Baron-Cohen and colleagues. This landmark study shaped research into screening for autism. The authors developed a measure called the Checklist for Autism in Toddlers (CHAT). The CHAT is a combined parent-report checklist, with a Health Visitor (HV) observation section. This section provides an opportunity for the health professional to rate the child's behavior according to what s/he observes during the appointment. Behaviors that were considered important in the etiology of autism provided the basis for the CHAT items. These included **joint attention, pretend play, social play, social interest, and imitation.** Initially, the CHAT was tested on a group of 41 children at high-risk for autism since they already had a sibling with autism. Results indicated that all those children identified to be at risk at 18 months on the CHAT received an autism diagnosis at follow-up (Baron-Cohen, Allen & Gillberg, 1992). This led to a large scale prospective screening study (Baron-Cohen et al., 1996) whereby over 16,000 children were administered the CHAT at 18 months. At follow-up six years later, it was found that when the CHAT did identify a child to be at risk for autism, it was very accurate in doing so (Baird et al., 2000). In research terms, the specificity was very high, at 98%. **However, the CHAT missed many cases of autism; that is, it failed to identify children to be at risk who later received a diagnosis – therefore the sensitivity was unacceptably low.**

There are numerous possible reasons why the CHAT missed cases of autism at 18 months. First, each item on the CHAT was structured in such a way that the behavior in question had to be definitely present or absent. For example the key items were phrased "Does your child ever pretend?" This meant that to "fail" an item, the child must never have produced the behavior and this may have been too stringent. More likely is that reduced frequency of behaviors such as pointing or pretending may be important in detecting risk for autism. Second, the key

items on the CHAT solely focused on joint attention and pretend play. The CHAT did not take into consideration other important behaviors that may be significant in the early identification of autism, including repetitive and stereotyped behaviors and sensory abnormalities. Third, screening at 18 months might have been too early to catch all children with autism since approximately 20-50% of children with autism exhibit developmental regression (Lord, Shulman & DiLavore, 2004) in language and/or social skills (Hansen et al., 2008) after 18 months. Lastly, during the 1990s when the CHAT was developed there was a noted increase in the prevalence of autism. The design of the CHAT was primarily based on aiming to detect what today would be called childhood autism, rather than the broader spectrum that includes AS, atypical autism, or PDD-NOS (it is relevant that AS was only officially recognized in 1994, during the decade of the CHAT studies).

In light of lessons learned through the course of these studies, **a revised version of the CHAT has been developed by Simon Baron-Cohen and his team.** The Quantitative Checklist for Autism in Toddlers (Q-CHAT) aims to enable parents to quantify autistic traits. The Q-CHAT bypasses the need for clinician observation, by relying entirely on parental report. If successful, this has the potential to reduce the burden on primary health care workers and could be a cost-effective method of screening large populations. The Q-CHAT retains the key items from the original CHAT but includes additional items that examine language development, repetitive and sensory behaviors, as well as other aspects of social communication. Each item contains a range of response options and does not force the parent to decide whether the behavior is definitely present or absent. This approach allows for the possibility that children at risk for autism and ASC show a reduced rate of key behaviors. In effect, this "dimensionalizes" each item (using a five-point scale of frequency), allowing for greater variability in responses and provides statisticians with more information with which to discriminate children who are developing typically from those on the developmental trajectory towards autism. Altogether, the Q-CHAT consists of 25 items, all of which endeavor to capture behaviors that may be characteristic of children who later receive a diagnosis of ASC. **All 25 items have been illustrated by a wonderful charity in the US, the Help Autism Now Society, founded by Linda and Paul Lee.** These illustrations help parents to understand about what each item is asking, and hopefully avoids misunderstandings. See Box 1 for some example Q-CHAT items and illustrations.

Box 1: Example Q-CHAT items and illustrations

SECTION 1

Please answer the following questions about your child by marking the appropriate circle.
Try to answer EVERY question if you can.

1. Does your child look at you when you call his/her name?
   - ○ always
   - ○ usually
   - ○ sometimes
   - ○ rarely
   - ○ never

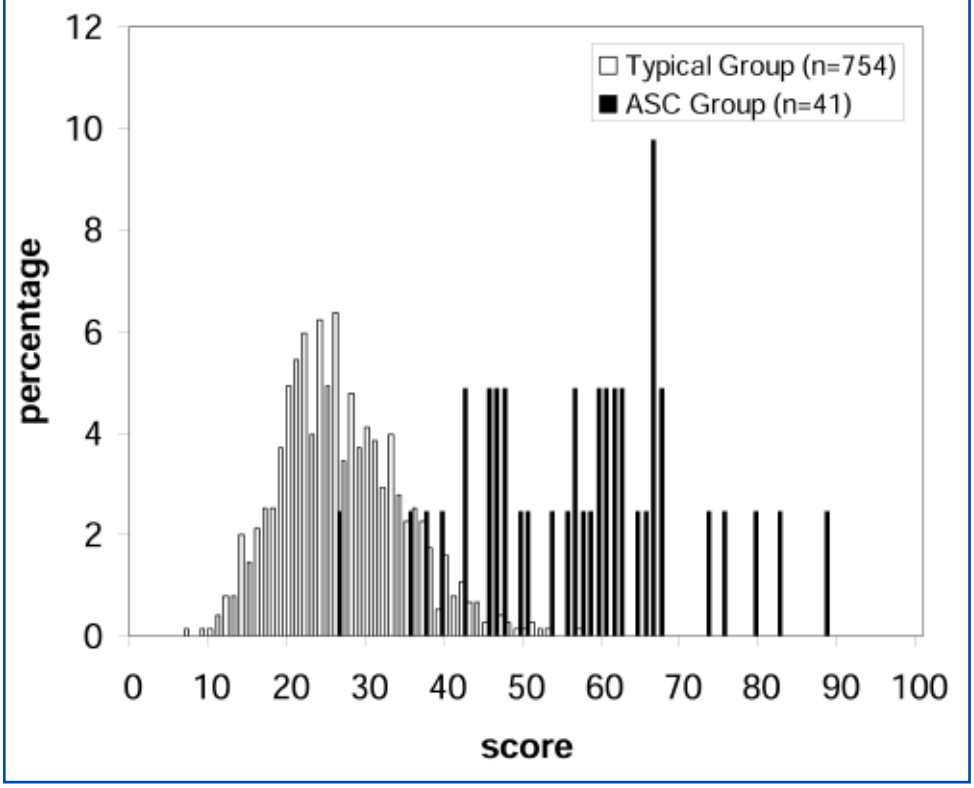
2. How easy is it for you to get eye contact with your child?
   - ○ very easy
   - ○ quite easy
   - ○ quite difficult
   - ○ very difficult
   - ○ impossible

3. When you child is playing alone, does s/he line objects up?
   - ○ always
   - ○ usually
   - ○ sometimes
   - ○ rarely
   - ○ never

Our pilot study has provided encouraging results. Two groups of children were compared. First, a group of 160 parents of children who already had a diagnosis of autism were asked to complete the Q-CHAT. These children were older than the age at

which the Q-CHAT is intended to be administered, but this group included 41 children who were all less than three years of age. A second group (754) of parents from a birth cohort of 18-24 month old toddlers also completed the Q-CHAT. The score distributions of children in the two groups were compared and a significant difference was found: **the group with autism scored higher on the Q-CHAT than the general population sample** (see Figure 1).

Figure 1: Comparison of Q-CHAT distribution between a selected subsample of Group 1 (N=41) and Group 2 (N=754) (from Allison et al., 2008)



Further, the distribution of scores on the Q-CHAT in the general population sample approximated a normal distribution.

This is the first toddler screening instrument specifically for detecting autism that has shown a range of scores in the general population that approximates a normal distribution. Interestingly, **boys scored significantly higher on the Q-CHAT than girls.** Sex differences have been found in other measures of social and communication abilities. For example, males score higher on the Childhood Autism Spectrum Test (CAST) (Williams, Allison et al., 2008); the Social Reciprocity Scale (SRS) (Constantino, Davis et al., 2003); and on the child, adolescent and adult versions of the Autism Spectrum Quotient (AQ), a quantitative measure of autistic traits in high functioning autism or AS in children, adolescents or adults of average IQ or above (Auyeung, Baron-Cohen, Wheelwright & Allison, 2008; Baron-Cohen, Hoekstra, Knickmeyer & Wheelwright, 2006; Baron-Cohen et al., 2001). The sex difference found here suggests two possibilities. First, boys may exhibit more difficulties in social, communication and rigid and repetitive behaviors than girls in early development (Leekam et al., 2007). Alternatively, the Q-CHAT may be more efficient at detecting autistic features in boys than in girls; therefore the sex difference found may simply be an artifact of the measurement instrument and sampling procedure. Per-haps the Q-CHAT is more sensitive to social and communication development difficulties in boys, and additional items would be required to identify more specific features in girls that are less obvious (Kopp & Gillberg, 1992; Wolff & McGuire, 1995) at this early age. Long-term follow-up of this pilot sample is ongoing to track the diagnostic outcomes of children who score high on the Q-CHAT. These data only represent initial psychometric work with this revised instrument.

A large-scale project is currently underway that aims to fully validate the Q-CHAT. We are undertaking to distribute 20,000 Q-CHATs to parents of toddlers aged 18-30 months in Cambridgeshire, UK. So far, we have sent out about 14,500 questionnaires and

"Long-term follow-up of this pilot sample is ongoing to track the diagnostic outcomes of children who score high on the Q-CHAT. These data only represent initial psychometric work with this revised instrument."

have had about 3,500 responses. We have developed a sampling strategy that we hope will maximize the capture of potential autism cases. This involves sampling across the whole score distribution, rather than only calling in children for diagnostic assessments with a high score. All high scorers will be called in, as well as children with borderline and low scores (the chance of being selected decreases as the Q-CHAT score lowers). Most other screening studies, such as the Modified Checklist for Autism in Toddlers (M-CHAT) (Robins, Fein, Barton & Green, 2001), only call in for assessment those who "fail" the screen. While our sampling strategy is labor intensive, time consuming and expensive, we hope that the information that we gather about how the Q-CHAT performs across the whole score distribution will enable us to make valid recommendations about its utility. We are using the gold standard diagnostic measures, namely the Autism Diagnostic Observation Schedule (Lord et al., 2000), Autism Diagnostic Interview-Revised (Lord, Rutter & Le Couteur, 1994) as well as obtaining a measure of IQ through the Mullen Scales of Early Learning (Mullen, 1995), and a measure of adaptive ability through the Vineland Adaptive Behavior Scales (Sparrow, Cicchetti & Balla, 2005). We are blind to the child's Q-CHAT score at the time of the assessment to minimize expectation bias. Also, because we have children with low scores on the Q-CHAT, not every assessment is with a child who is likely to have developmental difficulties, and this also helps to reduce bias.

Few research groups have attempted population screening for autism in very young children. There are practicalities and inevitable problematic outcomes (e.g., low positive predictive value, high number of false positives, low response) associated with population screening, which make it a daunting task. Research with screening instruments like the Q-CHAT and the M-CHAT are longitudinal projects and require many years of follow-up. In the UK, barriers exist in attempting population health research such as accessing the population because of data protection legislation, poor response, attrition at various stages, and cooperation and collaboration with our National Health Service. As there is no standardized screening or compulsory developmental check-ups in the UK, there is no already available opportunity to have the health professionals themselves involved in the screening. Instead, the Q-CHATs have to be mailed to the family home. Despite concerted efforts to maximize response, 25-30% is a typical response to an unsolicited questionnaire of this nature. We feel that face-to-face contact with a trusted health professional would help to improve response, but there are so many resource implications that this cannot currently be considered. When response is low, it calls into question how representative the responders are of the general population. The amount of bias that could be attributed to the non-responders is unknown and is not measurable beyond comparison of general population statistics. **In our pilot study, we did find a larger proportion of parents with higher levels of education, from higher socio-economic strata than is found in the general population. In terms of population screening, this may have implications concerning access to services if the high socioeconomic groups are more inclined to complete screening questionnaires.** In fact, results from a recent prevalence study of autism showed those children who had been previously identified and diagnosed with autism were more common in families with well-educated parents (Baird et al., 2006). Despite these challenges, they are not valid reasons to give up on population screening for autism. In the UK at least, better methods must be found to work collaboratively with the health professionals who contend first hand with conditions like autism. It seems that in the US, a more collaborative approach to screening for autism occurs between clinicians and researchers, a model that the UK health system should follow. Ultimately, earlier detection of autism may lead to improved outcomes through the implementation of specific interventions,

which will benefit not just the individuals themselves, but their families and society at large.

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Cover Artist: Luis Huete

Step up to the plate

For this issue, we pursued contributions for the cover a little differently, providing our potential cover artists with a theme for their illustration. We asked them to draw how you would "step up to the plate." As many of you know, we need financial support to keep ANOC going. We have received extensive positive feedback regarding how much our readers enjoy the content, and we appreciate the affirmation. We are now asking that those of you who have enjoyed ANOC over the years "step up to the plate," and donate what you are able.

Thank you for your continued support!

Luis is a 7th grader who attends Washington Middle School in La Habra California. He attends the S.U.C.S.E.S.S. class taught by Miss Myers. As demonstrated by the drawing, Luis is a skilled artist, who likes objects to be orderly and systematic. The drawing on the cover is a result of a challenge given to the students in Miss Myers' classroom to illustrate how you "step up to the plate." Luis enjoys playing and watching baseball, and would love to attend an Angels baseball game someday.

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Assessing the Social Mind in Action: The Importance of Informal Dynamic Assessments

By Michelle Garcia Winner & Pamela J. Crooke

Pamela J. Crooke (Left) & Michelle Garcia Winner

While most of us engage in social interaction/regulation intuitively, many students with social learning challenges who have good to excellent language and cognition (e.g., High Functioning Autism, Pervasive Developmental Disorder-Not Otherwise Specified, Asperger Syndrome and/or Attention Deficit Disorder) are weak in their ability to *think about how we think* socially. They also often lag behind their peers in the development of their social relationship skills. Professionals may regard this higher functioning group as being "quirky" with some level of "social skill problems," but struggle when determining whether or not these students should qualify for specialized services in our schools, given that they may demonstrate strong academic knowledge. Nonetheless, the peer group is generally very critical of how these students relate and may actively reject those who don't *fit in*. Furthermore, the deeper social learning challenges faced by this group may have an impact on how they interpret and respond to academic lessons that require social knowledge, such as reading comprehension of literature, written expression of essays, organizational skills and participating in peer-based (less structured) work groups. (Westby, 1985; Winner, 2000)

Social intelligence has an impact not only on our ability to live productively, but also on our ability to experience relative satisfaction throughout our lives (Hersh-Pasek & Golinkoff, 2003; Goleman, 2006). In fact, the set of tools used for social understanding and social regulation/communication in our early years is the same set required in adulthood to participate effectively as a member of society (i.e., hold a job and live with others in the community). Several years of clinical experience by both authors has led us to the conclusion that **IQ scores and achievement fail to predict whether or not an individual considered *high functioning* will achieve a similar level of success in adulthood** (e.g., maintain employment and develop satisfactory interpersonal social relations within their desired community).

Most of us would agree that the purpose of receiving an education is to prepare students to participate successfully in the adult world. Therefore it is reasonable to assume that those with significant social learning challenges need extra supports for learning about the social world, as well as for improving their capacity to develop social relationship skills. However, given that a neurotypical child's social knowledge and social skills are learned intuitively from their earliest days of life (Sabbagh, 2006), generally, teachers need only provide subtle cues to help these students learn to adjust their social behavior across different situations and grade level expectations. Therefore **direct, concrete and explicit social teachings are not taught as part of the daily core curriculum.** These more intensive teachings are usually taught by special educators, speech-language pathologists and psychologists/counselors.

In order to "qualify" for an Individualized Education Plan (IEP), a professional must demonstrate, via an assessment, that a student's deficits are *severe* enough across the school day to warrant more intensive services. Most professionals are taught to rely on standardized measures to determine whether or not a student is eligible for services. Thus, the most logical place to turn to assess a student's social thinking and related social skills would be through formal measures. However, significant limitations persist with the use of standardized tools for higher functioning students with ASD and related disabilities. **The dynamic nature of social interaction is not easily captured in a linear standardized test battery.**

Simmons-Mackie & Damico, in their seminal article, *Contributions of Qualitative Research to the Knowledge Base of Normal Communication* (2003)

acknowledge that communication is a synergistic and dynamic process that quickly becomes indecipherable when we try and break it down into parts in order to test specific aspects. Furthermore, speed is of the essence during the process of interpreting what another person is thinking/saying and coding our own related social response. It is expected that **we respond to one another in an interaction within milliseconds to 2 seconds** (Vuchinich, 1980). Unfortunately, standardized testing is a process that deconstructs and examines communication in parts, but fails to assess how a student integrates this information. This may result in test scores that demonstrate islands of social knowledge without the ability to combine this knowledge into a functional whole. In fact, Minshew and Goldstein (1998) state that **Autism Spectrum Disorders (ASD) are best described as *a deficit in the integration* of complex information.**

Many clinicians have reported experiencing frustration when trying to find assessment tools to fairly represent a student's social functioning in "real time." This frustration has been the impetus for the development of the strategies described later in this article. A student with very impressive test scores who *looks good on paper,* but has obvious social relationship issues, becomes perplexing to the diagnostician. These students have motivated the authors to better understand not only ***why*** this group should receive specialized teaching, but the specifics behind ***what*** should be taught.

What does it mean to assess social thinking and related social skills?

Before assessing social thinking and related social skills, one must consider the enormous task that a person's social mind must undertake in order to integrate and then respond when given social information. The term *Social Thinking* was coined by the first author to illuminate the fact that social skills do not merely exist as separate units of information learned through behaviorism. Instead as we age, including across the school years, social skills are the behavioral output of our more fine-tuned social thoughts. **To interact "appropriately" for our age, we need to consider what others are thinking and feeling as well as the expectations imposed by the situations in which we share our space or interact.** While this may seem well beyond the ability of the preschool or young elementary school child, it is not. This can be seen when observing a kindergarten class where most five-year-old children can work in a group of 20 students, adapting effectively to the teacher's expectations across time.

Winner (2000) developed the acronym, the **ILAUGH** model of Social Thinking to help explain to parents and professionals the many elements that contribute to Social Thinking:

I = Initiation of language to problem solve, ask for help or enter into social interactions that are not routine.

L = Listening with eyes and brain. We "listen" not only by hearing what people are saying, but also by watching what people are doing with their body language, eye contact, and facial expression as they speak.

A = Abstract and inferential thinking; making "smart" or educated guesses about what people mean by what they say or what they plan to do next based on what you know about them and the situation.

U = Understanding perspective: considering other's thoughts, emotions, motives, intentions, prior knowledge, belief systems and personality, simultaneous to doing everything else represented in this model.

G = Getting the Big Pictures (gestalt processing); focusing on the main idea rather than tangential details.

H = Humor and Human relatedness: Helping our students to enjoy the bond of human interaction to help motivate them to partake in learning more about all of the elements of social thinking.

It is also critical that we realize that social behavior is ever-changing based on our own stage of development. We expect students to demonstrate increasing nuance and sophistication in the ways they engage with each other, in their social thinking and related social skills with each passing year. When children are young they have relatively little social knowledge, thus may act in a more "immature" manner. But as they grow, we expect increasing maturity which is reflected by the expression of more finely

tuned social-behavioral responses, also referred to as social skills. Furthermore, social behavior is also dictated by our ability to "read" the changing "hidden rules" or "**hidden curriculum**" required in specific situations (Myles, Trautman, & Schelvan, 2004). Adapting to the complexities by considering and responding to all of these variables can best be understood as "complex social processing." To our knowledge, there is no standardized test or informal checklist that explores one's ability to socially adapt at a microscopic level, but it is at this level that we form perceptions of how people are "behaving" around us.

Remarkably, across cultures, we have subtle, nuanced behavioral expectations but we don't have a readily accessible way to describe when a child or even an adult is not "behaving" in a way that is expected. Yet interpreting those around us accurately and conforming our social behavior to situational demands, even for our youngest students, is considered a mandatory part of participating in the societies of our home, school and community. Therefore, creative approaches to assess this complex processing are in order.

Aspects of an Informal Dynamic Social Thinking Assessment Process:

The first step in assessing a student's social challenges is to understand the many ways in which we think socially and expect related social behavioral adaptations in others (Winner, 2007). As we acquire this knowledge, we can become better observers of our student's social behavior within social situations. Our goal is to not only observe in structured and unstructured naturalistic situations (Weatherby, 2006), but to also learn what about the student's social knowledge that may support or fail to support social behavioral or social academic expectations.

If a professional works in a school environment, observing a student in the naturalistic setting is an invaluable part of the assessment. Professionals may ask, "Where are the guidelines or written social standards on which we can base these observations?" The answer is that the professional has to observe, to some extent, the student in the setting to determine if the behavior of the student they are assessing is **"expected" or "unexpected."** For example, if a student is "blurting" out in class, it is important to note that to some extent all students "blurt" on occasion in a classroom. Thus it is not that the student has blurted, it is whether his level of blurting significantly exceeds the expected "norm" of the other students in the classroom.

If a professional does not work within the school, it is important to remember that social behavior happens 24 hours a day and so the assessment should begin in the waiting room or at the initial meeting. Knowledge of general social developmental expectations of students across childhood and into adulthood is helpful. This knowledge is most easily gained by **actively observing "normal" behavior** in a given situation, whether it is in a grocery store, a school, home, etc. A recent example of this occurred when a 13-year-old boy came for a first visit to the authors' waiting room. The boy stood very close, spoke in a very loud voice, and described his Playstation game in a very, very excited manner. This behavior may have been "expected" for a 6-year-old but was clearly "out of the norm" for a 13-year-old. Thus, the assessment had already begun.

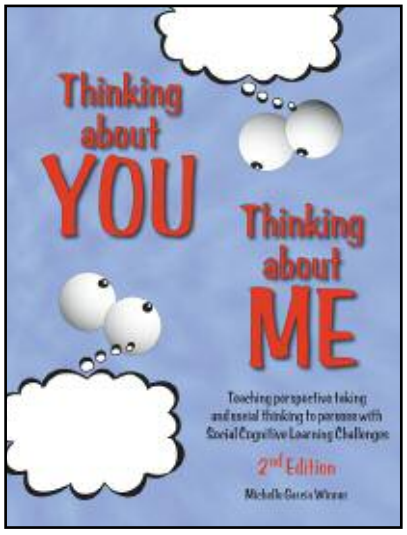
Winner (2007) created a number of informal assessment tasks to better understand how individuals process and respond to social information that is complex in nature. The following is an example of one task within an informal *Dynamic Social Thinking Assessment.* The tasks in this assessment are designed to explore a student's thinking in "real time" and are a critical aspect of assessing the ability to relate effectively with others. This core task explores how students use their eyes to process and respond to other's thinking. The task will be described in three parts: a. the task itself, b. how this task relates to developing social interactive competencies, and c. how this knowledge is incorporated across a school or home day using the paradigm of the ILAUGH model of social thinking.

Thinking With Your Eyes:

a. *Task description:* The examiner works with the student in a relatively small room and asks him to guess what he thinks the examiner might be looking towards. The examiner can cue the student by telling him that the task relates to look-

ing at her eyes. If the examiner is wearing glasses, she should take them off. The examiner then looks at one object in the room that is 8 feet or less from where the examiner is sitting. The student is to focus on what the examiner is looking at, follow her eyes and then state aloud what he or she thinks the examiner sees. For example, if the examiner is looking at a clock, the student should guess she is looking at the clock. The examiner should not correct the student if they are wrong.

After the examiner determines the student's ability to follow the examiner's eye gaze, she can then say, "Now I want you to guess what I am thinking about and this also has to do with my eyes." Now she should look back towards some of the objects from the previous task. For example, if the student thinks she is looking at the clock he should now state she is thinking about the time. If the student can do this, it indicates that he is able to **shift his observation of another person's eyes from thinking about what they *seeing* to inferring the concept the examiner may be considering or *thinking*.**

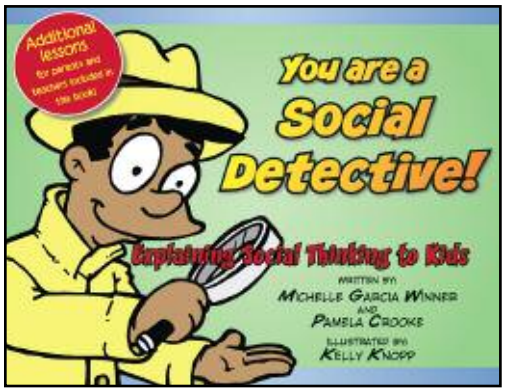


b. *Assessment of social knowledge:* In the research on early development, the ability to follow eye gaze is called **"Joint Attention"** and it **is expected that neurotypical students are proficient by 12 months.** When a student is limited in his ability to "read someone's eyes" or what we describe as "thinking with your eyes about what someone else is thinking," it impacts social understanding of the situation. For example, a student is required to determine what the teacher may be thinking in the classroom each and every day (e.g., observing the teacher to figure out whose turn it is to speak or what is expected from the students). This is also the case when two or more individuals are actively engaged in a discussion or conversation. If you take time to observe this skill in yourself, you will begin to notice how much we depend on watching and reading others' eyes to figure out their intentions, etc.

c. *How this knowledge is incorporated into the school and home day:* Awareness of another person's eyes (and related thoughts) is a central skill for understanding how a person works as part of a larger group in a classroom as well as how to relate to others through play and conversation. It is also considered a part of our own personal safety as we monitor what others see as it relates to thoughts they may be having about us. Typically, when a student has "poor to good eye contact" we determine they need to learn to use appropriate eye contact. What we may not realize is that they are lacking more than the understanding of eye contact itself; many students with social learning challenges are inefficient social thinkers who do not easily making the eye-gaze/social thinking connection. With regards to the ILAUGH model of Social Thinking the concept of "thinking with your eyes" is central not only to "Listening with eyes and brain" but also "Understanding Perspective." The ability to efficiently think about what someone else is thinking also leads to better abstract/inferential thinking as we infer what people mean by what they say, based on what we think they might be thinking about.

Many instances of using this task in hundreds of individuals of all ages has shown us that how a person performs on this task cannot be predicted based on their diagnostic label, IQ scores, or language skills. The task is unique in that it assesses the ability to actively engage in Social Thinking in the moment of social interaction and appears to be a crucial aspect of the assessment of social competencies. Winner (2007) has described a number of tasks

that attempt to capture a more "real time" assessment of social thinking and related social skills and discusses how the information gleaned from these tasks helps to more accurately predict a student's actual social processing and responding.



A comprehensive assessment should include a blend of standardized assessments, checklists of social functioning, such as **Bellini's Autism Social Skills Profile (2006), and Informal Dynamic Measures of Social Thinking.** However, if the professional has time constraints, the least informative method for predicting how a student relates and responds to social information in real-time interactions and in their core curriculum is through standardized tests. In the process of understanding the social mind in action, it is critical to consider that formal tests are not the best and most accurate indicators of a student's ability to function in day-to-day social and academic skills. Instead, this article has given one task to inspire diagnosticians to dig a little deeper into the assessment of the social mind; there are many other creative ways in which dynamic social thinking and related social skills can be explored. Professionals should realize they are on the cutting edge of a new field for which the research has not been completed, but the need for creativity combined with continued learning about the complex social mind and its many functions is crucial. Individuals with social learning challenges are here now and they can't wait for our field and our research to evolve.

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A Comprehensive Speech-Language Assessment: The Importance of a Collaborative Approach for Individuals with Autism Spectrum Disorders

By Rachael Gray

A comprehensive valid assessment of an individual's communication skills is the foundation on which diagnosis, intervention strategies, and referrals are determined. Due to the remarkable heterogeneity among individuals with Autism Spectrum Disorders (ASD), assessment approaches will differ according to the unique needs of the individual, as well as the individual's family (National Research Council, 2001; American Speech-Language-Hearing Association, 2005b, 2006a). Keeping social and communicative competence as the central focus, a comprehensive assessment should include an evaluation of the individual's communicative skills by both informal measures in natural contexts and standardized/norm-referenced assessments.

By evaluating an individual in his/her natural environment, a clinician is more likely to discover information that will lead to intervention strategies that enhance the individual's quality of life across school, home, and community settings (American Speech-Language-Hearing Association, 2006c). In addition to including observations across settings, the members of an individual's medical (neurologist, psychiatrist, pediatrician), educational (teacher, district autism specialist, inclusion specialist), and therapeutic team (school-based SLP, OT, psychologist, behavioral specialist) should be consulted. A broad-based multidisciplinary consensus panel stressed the importance of interdisciplinary collaboration in assessing and diagnosing ASD, due to the complexity of these disorders, the varied aspects of functioning affected, and the need to rule in or rule out other disorders or medical conditions (Filipek et al., 1999). It is important to include a variety of observers and informants in order to provide a comprehensive picture of an individual's communicative behaviors as a function of specific contexts and communication partners.

While it is a challenging task to conduct a truly comprehensive assessment that includes the aforementioned components, due to the amount of time and the differing philosophies of professionals that may be involved, the results of an assessment that includes an individual's family, peers, and professional team will provide a detailed picture of the existing communicative strengths and weaknesses, leading to appropriate program development.

Informal Assessment Procedures

Family Interview and Observation

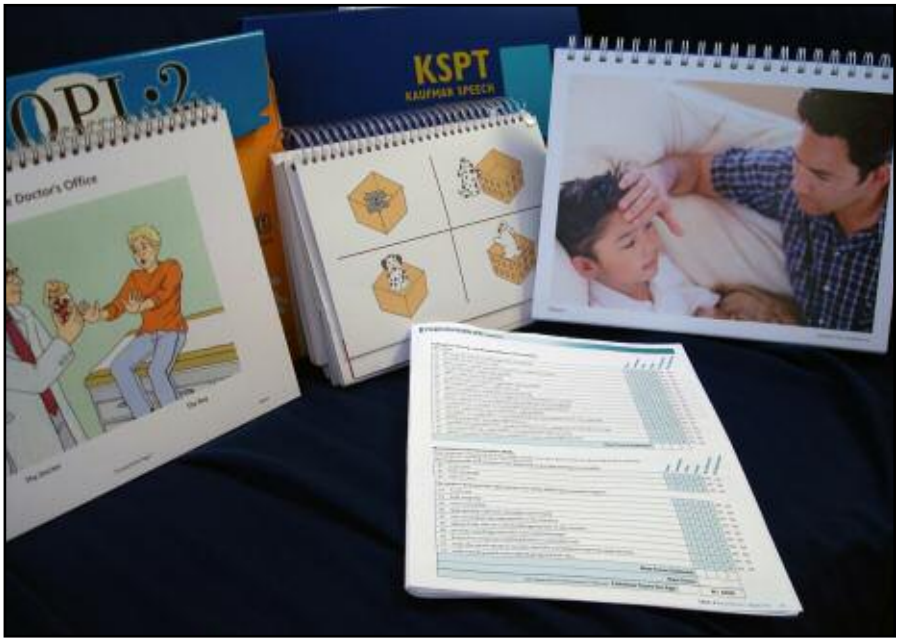
Family participation is critical to obtain developmental history, current level of daily functioning, and future goals of the individual with ASD (e.g., Domingue, Cutler, & McTarnaghan, 2000; Lord & Corsello, 2005). The combined use of interviews, communication checklists, and observations is useful in collecting this information.

a comment from our readers...

"This is a very useful, readable, practical publication. ANOC brings together articles from many reliable, knowledgeable sources and puts them into a format that is accessible to the average reader. While some articles are technical, they are readable, and almost any reader can find useful articles that will work for his or her particular situation. People who read ANOC are more informed and more empowered for having read it."

The intake interview should provide historical information from the individual or family member. This is also where you will likely learn about the other professionals involved in the individual's care and gain insight regarding the individual's daily life (schedule, activities, etc.).

There are several checklists available that are related to communication and social/behavioral skills. The *Pragmatics Profile* of the *Clinical Evaluation of Language Fundamentals, Fourth Edition, Children's Communication Checklist-2,* and the *Receptive-Expressive Emergent Language Test–Third Edition* are commonly used by speech-language pathologists in collaboration with family members, teachers, and/or other caregivers.



Assessments commonly used in a speech-language evaluation for a child with ASD

Observations and language samples in the home environment can be quite helpful in providing information about the family culture and how the individual with ASD is communicating within the family unit. Also, observations on the playground, during story time, and during group learning in the classroom will provide information regarding the individual's ability to reference his/her peers when necessary, problem solving skills, flexibility with language, and understanding of the subtleties of language. Observations can be done in-person or through video; either way, observations should be made over several different days and during different activities to obtain a true sample of the individual's communication skills across contexts.

Standardized Speech-Language Assessment Measures

Speech Production

Approximately one-third to one-half of individuals with ASD present with significant difficulties producing a variety of consonant sounds and using more complex syllable structures, such as those in multisyllabic words. The nature of these difficulties is not well documented in the literature; however, underlying difficulties may include challenges with oromotor planning and/or delays in phonological development (American Speech-Language-Hearing Association, 2006; Bryson, 1997; Lord & Paul, 1997; National Research Council, 2001). Also, limb apraxias, oral apraxia, and apraxia of speech have been frequently reported for children with ASD (Boyar et al., 2001; Page & Boucher, 1998; Rogers, Bennetto, McEvoy, & Pennington, 1996; Seal & Bonvillian, 1997). Therefore, a comprehensive assessment should include a complete oral-facial examination and an assessment of articulation/phonological processes and/or an assessment of speech praxis; collaboration with an occupational therapist can be useful when assessing apraxia and motor planning deficits.

Language

The aforementioned home, school, and play observations will play a vital role in the assessment of the language skills of an individual with ASD; however, standardized language assessments provide an individual's level of functioning in comparison to his/her peers.

The field of communication disorders and sciences has generated multiple, highly respected, stan-

dardized language tests that evaluate syntactic, semantic, and metalinguistic skills; however, the tools to assess pragmatics are seriously insufficient. In fact, using a standardized measurement of pragmatic language without careful observation of the individual in his/her natural setting could lead to a gross misrepresentation of social skill level. For example, many individuals with high functioning autism can look at a photograph or an illustration and describe what *should* be done in a given situation, but would not demonstrate the ability to appropriately use those same skills in the real-world experience. Therefore, it is critical to recognize the limitations that standardized pragmatic tests may have for individuals with ASD and insist that they not be used in isolation, but to complement the results of other language measures and informal findings.

When considering the results of language and social communication testing, collaboration with medical, mental health, and behavioral professionals is critical in assessing the possible effects that attention, behavioral, and psychological symptoms may have on the findings.

Discussion

As a speech-language pathologist in private practice, I have relatively easy access to a variety of natural settings. I greatly appreciate the educational and professional teams that welcome a collaborative approach. Individuals with ASD require intensive intervention across disciplines, and it is our job, as professionals in the field of autism, to work as a team to provide differential diagnosis that will lead to an individualized program that improves the individual's quality of life across school, home, and community settings.

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Assessing Symbol Levels for Core Visual Supports

By Barbara Bloomfield

An often-cited best practice in the education of students with Autism Spectrum Disorders (ASD) involves the use of visual supports across the school day. Engineering of the classroom space, the daily visual schedule, a myriad of routine-specific embedded schedules and task organizers, and scripted communication aids are but a few of the visual teaching supports that classrooms sometimes make available to students with ASD. These, as well as several other categories of visual instructional aides, are often referred to as "core" supports.

Unlike the variations in thematic materials during the school year, the types of core supports available to the student are presumed to remain relatively constant. Integral to each of these supports is visual language, i.e., symbols used to clarify specific information for the student. For example, the daily visual schedule for a particular student offers information in picture symbol form regarding the number and sequence of upcoming classes. Over the course of the year the schedules can change in type, size and number of displayed symbols. Ideally the change would be very gradual and carefully matched to the increasing skills of the student.

How does a student's educational team determine the optimal level of visual language that will be featured on core supports? Is there a "rule" or widely accepted decision making standard that teachers and therapists can turn to as they construct an information system for the student? Most educators would probably agree that a student should only be exposed to abstract symbol systems, e.g., printed words, if these have previously been paired and systematically introduced by fading in symbols containing a large printed word with increasingly smaller pictures.

EXAMPLES OF CORE VISUAL SUPPORTS
- Engineered classroom space
- Daily visual schedule
- Mini schedules
- Task organizers
- Communication aids

Do educators planning core supports sometimes confuse literacy skills and functional communication abilities? What is the primary goal, for example, of the daily visual schedule? If we were to conclude that it is to assist the student in getting from one routine or event to the next independently, it soon becomes apparent that the visual language selected should be so salient or understandable to the student that he can easily and almost auto-

matically reference it as he moves through the school day. The symbol level chosen may or may not be the most sophisticated visual language we could offer the student. From the student's perspective, however, it should be the most meaningful.

When evaluating visual language levels to be used in core supports for students with ASD, it is suggested that educators consider the following:

1. Family input regarding the type of **visual information most pursued/preferred by the student** in the home setting. Does he pay attention to books at any level? Magazines? Does he show an interest in looking at catalogs, newspapers, flyers, coupons, etc.? If so, what are his favorites? Do they tend to feature lots of colorful illustrations or are they mostly print?
2. The outcome of "at the table" matching activities to determine the **highest level at which a student is able to connect a target symbol to the three-dimensional object it represents.** The ability to match to a three dimensional item is at the heart of successfully using core visual supports. A student whose daily schedule consists of single line drawings, for example, must be able to match a picture symbol to the three dimensional reality of the reading corner in order to understand that he should transition to reading group. A suggested minimum standard for successful matches would involve 12 to 24 objects representing both highly preferred and relatively neutral items.
3. Observations involving the **fluency, i.e., accuracy plus speed, of the student's matching patterns.** How quickly and easily was he able to correctly make associations during table activities? When presented with multi-tasking challenges during matching activities, was he able to override competing signals or bids for his attention well enough to accurately (if not fluently) complete object-symbol matches?
4. Is the student able to **generalize matching accuracy from table-tasks to a range of settings or to a variety of routines?** For example, matching opportunities that were originally introduced by a student's classroom staff could later be extended to both speech and language therapy and occupational therapy

sessions away from the classroom setting.

A student's ability to accurately and fluently perform a task in the face of multi-tasking demands and across a range of routines and settings is viewed as skill mastery. It's suggested that, if at all possible, the visual language selected for a student's core supports should be at a level that has already been mastered by the student. He is then freed up to understand and follow through on the true goal of the visual support, e.g., in the earlier example of a visual schedule, the goal would be to correctly transition to the next targeted routine.

Following initial selection of the visual language to be used in core supports, it's suggested that an attempt be made to establish an accuracy baseline for support use. The staff can then periodically collect data to determine how quickly a student was able to successfully accomplish a task or routine through use of the support and how well this success is maintained over time.

Another important decision is when to move on to a more advanced level of symbol use in instructional supports? After three months of successful symbol use? Six months? A year? Some years ago, Gary Mesibov, Director of Division TEACCH (Treatment and Education of Autistic and related Communication-handicapped CHildren), reported that the two most common errors made by educators who provide visual schedules for their students with ASD are: choosing a visual symbol level that is too advanced or that has not been mastered by their student and, once a schedule level has been mastered, moving that student too quickly to a new and more challenging level. In addition to helping a student become a competent user of visual supports, he speculated, shouldn't our goal also be for the student to become comfortable and even confident in his ability to meet classroom expectations with the help of well-selected, well-planned visual supports?

AN IMPORTANT THOUGHT FROM GARY MESIBOV: Students should not only become *competent* user of visual supports but *confident* users.

Choosing when to transition a student to the next level of visual language use for core supports would ideally be a decision in which the entire educational team has input based, in part, on data collected across settings by more than just a single team member. Although terms like "comfortable" and "confident" may be meaningful to team members, they are nonetheless difficult to objectify and score. The final decision, then, will need to be one of consideration of objective factors which can be scored, e.g., accuracy and fluency, along with more subjective recommendations.

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The TEACCH Transition Assessment Profile: Assessing Individuals with Autism Spectrum Disorders with an Eye to Success

By S. Michael Chapman

History and Rationale for the TTAP

Planning for the future is a difficult task for most people. For adolescents and adults with autism, this task is even more difficult for them, their caregivers, educators and support networks as they strive to develop a comprehensive plan that takes into account the vocational, residential and recreational opportunities that lead to positive adult outcomes. In an effort to help provide guidance in developing more effective transition planning for adults with autism, in the mid 1980's, Division TEACCH (Treatment and Education of Autistic and related Communication-handicapped CHildren) created the Adolescent and Adult Psycho Educational Profile, or AAPEP. The AAPEP was designed around what the positive adult outcomes and opportunities for adults with autism looked like at that time. However, over the last 20 years, the opportunities for individuals with autism have broadened and the old AAPEP was not as effective in guiding good transition planning. Therefore, when rewriting the AAPEP, Division TEACCH used the information learned from their Supported Employment and Residential programs. In addition, evidence from other successful transition programs as well as information based on current research and changing education laws, to create a more effective and useful assessment tool. The TEACCH Transition Assessment Profile (TTAP) is that tool.

The TTAP was designed with older children and adolescents as the primary focus. However, the tool has been used by the TEACCH Supported Employment Program as a means of providing effective assessment and goal development for adults as well. Current research and experience has shown that assessment and transition planning needs to start at a younger age. The current Individuals with Disabilities Education Act (IDEA) requires that a transitioning adolescent has a needs evaluation assessment and a transition plan in place no later than age 16. IDEA also states that the needs evaluation assessment should include both formal and informal measures. The TEACCH Transition Assessment Profile was designed to meet those requirements and to give educators a means of complying with federal law. In an effort to do this, the TTAP includes the following features.

1. It is an assessment designed for individuals with Autism Spectrum Disorders. Currently there are few assessment tools designed for individuals with ASD at all levels of cognitive ability and adaptive functioning.
2. The TTAP assesses the six core functioning areas for individuals with autism that are most important for developing positive adult outcomes. These six areas are: vocational skills, vocational behaviors, independent functioning, leisure skills, functional communication and interpersonal behavior. In addition, the TTAP provides a systematic way of identifying long-range goals in each of these critical areas.
3. The TTAP looks at performance of these skills areas across multiple environments. By gathering information from multiple environments, such as home, school, work and direct observation, the TTAP helps identify weaknesses and strengths in each area that are important for future goal development.
4. The TTAP uses a unique scoring system that employs a Pass, Emerge and Fail scale to identify and document a student's present level of performance.
5. The TTAP uses a variety of visual supports in an effort to help educators identify those supports that are most effective for individuals

with ASD. Current research shows the individuals with ASD need physical and visual structures to assist with skill development retention, while IDEA requires that an effective assessment tool should identify life skills and the accommodations required by the student to achieve the greatest level of independence in achieving and maintaining that skill. The TTAP assists with all of this.

The Formal Section

The TTAP has a formal section that is comprised of three different scales: two Interview scales and a Direct Observation scale. The Direct Observation scale provides a structured set of test items that are administered in a controlled and systematic manner, similar to most other intellectual and skills assessment. It consists of 72 total test items with 12 test items in each of the six domains: vocational skills, vocational behaviors, independent functioning, leisure skills, functional communication and interpersonal behaviors. Now let's look at what each of these areas encompasses and review sample items from the test.

Figure 1: *Vocational Skills: Direct Observation Item 7, Travel Kit Assembly*

Vocational Skills looks at specific technical skills. During the Direct Observation we look at such tasks as sorting, counting and measuring. In Figure 1, we are looking at packaging and assembling of items in a travel kit. The student must look at the picture and create a package just like the picture. Note that there is an item presented that is not in the picture. The student must recognize this and be able to assemble the items correctly. If the student cannot, we can present a different set of visual instructions to see if this clarifies the task (Figure 2).

Figure 2: *Vocational Skills: Direct Observation Item 7 Travel Kit Assembly with different visual supports*

Vocational Behaviors looks at relevant work related behavioral skills, such as stamina, the ability to stay on task and the ability to work without supervision. In Figure 3, we see a set of items that looks at several different vocational behaviors. During this portion of the test, we observe productivity, organization and speed, as well as how an individual works without supervision or when a distraction is present, like a phone or radio.

Figure 3: *Vocational Behavior: Direct Observation Items 13-18, Assembly line, Distracted by noises, Works continuously, Without supervision*

Independent Functioning covers the areas of self-help and self-guidance. Some of the items in this section include the use of money, eating habits and the ability to follow a schedule. In Figure 4, we assess if an individual can recognize money and make simple monetary calculations (Figure 5). We

Figure 4: *Independent Functioning: Direct Observation Item 26, Recognizes money*

Figure 5: *Independent Functioning: Direct Observation Item 27, Calculates monetary amounts*

ask for the amount verbally and if the person has difficulty, we use visual cards that request the same amount.

In **Leisure skills**, we look to see what activities the individual uses for socially acceptable and pleasurable activities. In this section weexplore the ability to sustain interest in an activity, stop that activity at a prescribed time and to play solitary and cooperative games. In Figure 6 we look at the person's ability to play darts, take turns and record the score.

Figure 6: *Leisure Skills: Direct Observation Items 39, Plays darts and Item 40, Records score*

Functional Communication items assess the minimum communication abilities necessary for interactions in vocational and residential settings. Some of the skills reviewed in this area include the ability to communicate basic needs and to comprehend verbal and visual instructions or directions. In Figure 7, we examine the individual's ability to read and follow simple written instructions. Each card is presented to the individual one at a time in order to see if he understands and will follow the direction.

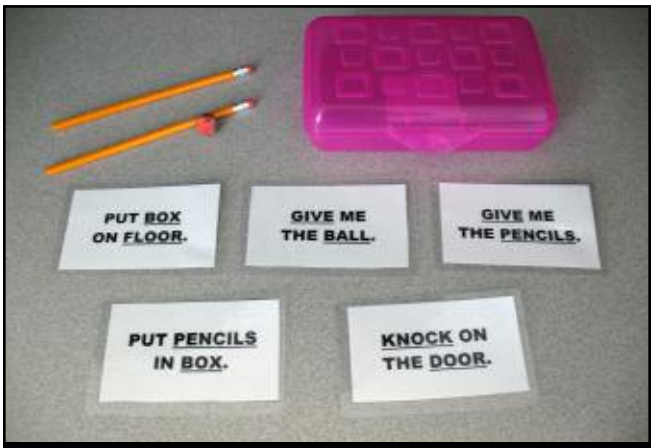


Figure 7: *Functional Communication: Direct Observation Item 58, Follows written instructions*

Interpersonal Skills relate to the social skills and abilities of the individuals with autism. Many

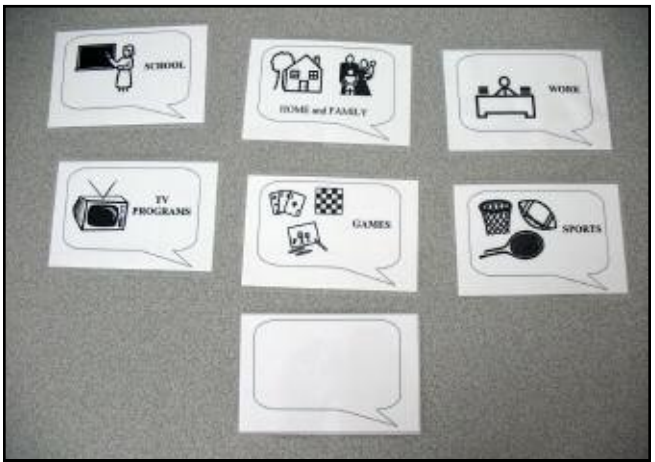


Figure 8: *Interpersonal Skills: Direct Observation Item 71, Engages in conversation*

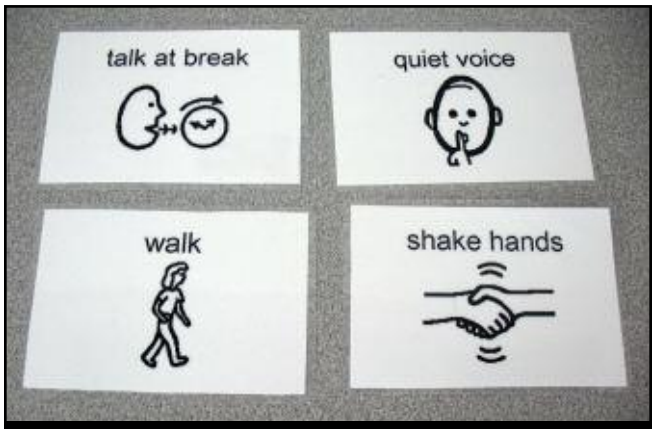


Figure 9: *Interpersonal Skills: Direct Observation Item 72 Follows visual rules*

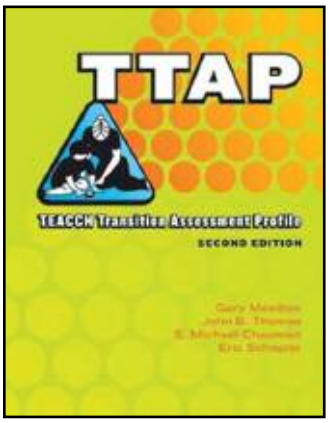
of the items in this section are directly related to the interactions between the examiner and the individual. Examples of items include appropriate initial greeting, smiling appropriately, responding to the examiner throughout the test and positive personal interactions between the examiner and the individual. In Figure 8, we use visual cards to assess the individual's ability to carry on a social conversation. In Figure 9, we assess whether they can understand and use visual rules for appropriate social interactions during the testing period.

In addition to the Direct Observation scale, there are two interview scales: the Home scale and the School/Work scale. These two interview scales are administered in an effort to gain data on the relative skills present in each of these areas as observed by the person with the most knowledge about the person with autism. As with the Direct Observation scale, there are 72 items in each of the two interview scales, with 12 items in each of the six life domains.

The total administration time for the Direct Observation scale is typically one-and-a-half to two hours. However, the TTAP was designed so that items can be presented in any order and even over multiple sessions. This makes it easier for teachers who may find it hard to set aside so much of an instructional day at one setting. The two interview scales take about an hour each. When completing the formal section of the TTAP, the comparison of information across all three environments offers some of the most powerful data for creating effective transition/habilitation plans. By noting areas and environments where the data shows insufficient skills, we are better abled to recognize where to intensify our educational focus.

Informal Section of the TTAP

As good and effective as the Formal Section of the TTAP is, it only assesses 216 total skills. In adult life, we may use more than 216 skills even before breakfast. When using the original AAPEP in our Supported Employment Program at Division TEACCH, we soon realized this and started to create a list of other skills that we found were common in many of the jobs we were locating for individuals with autism. This list, though not exhaustive, is a compilation of those common transition goals and objectives from more than 20 years of Supported Employment services to more than 400 adults with autism in the state of North Carolina. As a result, when writing the TTAP, we knew that we had to include this list in the manual. This addition to the TTAP is called the Informal Section and is the most powerful and useful part of the TTAP.



Both IDEA and best practice state that we need to use informal assessments in transition planning for adolescents and adults with Autism Spectrum Disorders. The TTAP is designed to assist the education system and adult provider agencies with meeting this mandate and with documenting the student's progress toward achieving the necessary skills

Table 1: *Excerpt from the Vocational Behaviors Section of the Cumulative Record of Skills*

Vocational Behavior SKILL	Score: Record Setting and Structure
Stamina – Note tasks that student completes at a steady, fast pace: • for 10 minutes, • for 20 minutes, • for 30 minutes, • for 1 hour, • for 1 1/2 hours.	
On Task Ability: • Stays on task with supervisor or coach in close proximity, • Stays on task with coach across room, • Stays on task with coach in next room.	
Sustains Quality of Task: • Sustains quality of task during short intervals, • Sustains quality of task over one hour, • over 2 hours, • over 3 hours, • over one week, • over six weeks training period.	
Response to Interruptions: • Responds to visual cue to stop one job (activity) and go to another (does not return to old job independently when finished), • Responds to verbal cue to stop one job and go to another (does not return to old job when finished), • Responds to visual cue to stop job and go to another (independently returns to old job and finishes), • Responds to verbal cue to stop one job and go to another (independently returns).	

that lead to positive adult outcomes. To do this, the TTAP uses three main tools: the Cumulative Record of Skills, The Community Site Assessment Worksheet and the Daily Accomplishment Chart.

- The Cumulative Records of Skills (CRS) is a 49-page reference document that is used by the teacher or job coach to determine the skills needed by the student in a community setting.

  The skills in this document are those found to be most commonly used by individuals with ASD in employment settings. In addition, the CRS is used to document the overall progress of the individual and to create a portfolio or résumé for the individual with ASD. This Cumulative Record is a history of all the student has been taught over their transition years. A small sample of goals can be seen in Table 1.
- The Community Site Assessment Worksheet (CSAW) is a tool used to help the teacher identify the specific skills in a community site and to record the student's level of performance on the first and last days of the training period.
- The Daily Accomplishment Chart (DAC) is a

data collection tool to record progress or lack of progress toward goal achievement while at a community site. Each day, the teacher or job coach will record the student's level of performance as a Pass, Emerge or Fail. By examining the data recorded on this tool over several days or weeks, the transition or assessment team may determine that additional visual supports are needed or that they need to be modified to achieve goals that are not at a *passing* level.

When using the informal section of the TTAP there are some recommendations that have been found to be very important through research and observation.

1. Research has shown us that informal assessments need to take place in natural settings, not just in a classroom. As such, the TTAP recommends that a student have varied community opportunities during the transition process. This means that a student should have 3-4 unique community sites assessed each school year, for a total of between 12 and 26 different sites by the time the student graduates. These sites should be 9-12 weeks in length and the individual should go to them at least 1-3 times each week for an hour or more each time.
2. The informal assessment process allows us to look at many different types of structures and visual supports that a person may need in order to complete an activity. We know people with ASD have difficulty with generalizing skills from one environment to the other. Through informal assessment, we can identify those visual supports that will assist with the generalization of skills across multiple settings.
3. The informal section needs to start early for those students still in school. Though IDEA states this review should be conducted by age 16, at TEACCH we feel it should be addressed as early as possible in a student's education. Waiting until the last year is not effective and has little likelihood for success.

Summary

Performing the proper assessment for individuals with autism is crucial to long-term achievement of positive adult outcomes. Current research and education law states that in order to provide effective transition services for individuals with Autism Spectrum Disorders, we need to use both formal and informal measures. In the formal section of the TTAP, educators and job coaches are able to establish a baseline of what the student may or may not know, as well as possible teaching strategies. To build upon what we learn, the Informal Section of the TTAP helps develop a process that fills in the gaps and offers true experiential learning opportunities for individuals with autism. The TTAP is designed with these goals in mind and to meet IDEA requirements, thus giving educators a method of documenting outcomes as well as giving them some guidance in where to focus their efforts both in the classroom and in community settings. If we are to provide students with autism the greatest possible chance at success, we need to realize that the first step is a thorough and comprehensive assessment of their functional skills. When we fully understand these students' needs, then, and only then, can we help them achieve their dreams.

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The S.U.C.S.E.S.S. Project's Assessment Focus Academy (AFA)

By Andrea Walker

Issues related to assessment of children with Autism Spectrum Disorders (ASD) have had a significant impact on school districts within Orange County and statewide. Educational assessments to determine eligibility and the unique educational planning for children with ASD were of concern to families and staff, often anxiety-producing and a point of contention. These disputes involved areas of eligibility, components of a comprehensive assessment, interpretation of assessment results, educational planning and/or service recommendations resulting in negative consequences both fiscally and to the credibility of personnel and program quality.

The availability of research-support recommendations and best practices in assessment ("Educating Children with Autism" National Research Council report, (2001); California Department of Developmental Services' "Autism Spectrum Disorders: Best Practice Guidelines for Screening, Diagnosis and Assessment," (2002); and expert practitioners in the field) provides a framework for comprehensive and defensible assessments. Our educational teams need to be highly trained and competent in these areas.

To address this identified need, the S.U.C.S.E.S.S. Project of Orange County conducted a Situational Appraisal within the 13 Orange County Special Education Local Plan Area (SELPA) in January 2003 to clarify concerns and determine priorities. One of these concerns focused on a *"lack of [a] defined and coordinated delivery model across the Autism Spectrum in the areas of training and supervision of staff, identification of student needs and development of effective educational programs."* The area of assessment had been identified as a high priority.

Purpose: The purpose of establishing the Assessment Focus Academy (AFA) was to support selected participants in conducting effective and comprehensive evaluations for students. These thorough assessments will determine eligibility, identify the impact of the disability on learning and lead to the development of an Individualized Educational Program (IEP).

A committee was formed in summer of 2004. Members included local consultants, Orange County Department of Education staff and S.U.C.S.E.S.S. Project representatives.

The goals were:

1. To establish the outcomes for the Assessment Focus Academy (AFA) series–what is our "vision?"
2. To address the assessment needs across Autism Spectrum Disorders (ASD) and range of developmental levels from Mild to Moderate to Severe, within placements for preschool through secondary education and into adult transition.
3. To discuss the issues surrounding assessment and its role in educational planning and programming, such as:
   - Defining a comprehensive protocol for use at the various developmental levels;
   - Defining the role of the "Best Practices for Autism Assessment and Diagnosis" Guidelines (Department of Developmental Services);
   - Addressing "borderline" students;
   - Identifying the realities of assessment (i.e., overlapping of disciplines, time constraints and streamlining the process); and
   - Developing and defining "teams" (members, team building, reaching consensus/problem solving).

Assessment Academy: In the Fall of 2004, the AFA offered its first Tier One, Group A, within a five part series, designed to address two strands/levels: ***Preschool/Elementary*** and ***Secondary*** aged students across the spectrum of autism and across levels of functioning. Topics included: comprehensive and defensible assessments, profiles of strengths and weaknesses, diagnostic tools, interpretations of results, report writing, educational planning and

team dynamics. The Assessment Focus Academy utilized local experts in the field of autism. The teams involved in the training were encouraged to disseminate the information within their local district/SELPA.

A second tier of mentoring for this first group of teams was designed for year two. New teams, Group B, began the first tier in Fall of 2005.

We have just completed a fifth year of AFA (see chart below) with over 650 staff attending Tier 1 (about 27 hours of instruction) and Tier 2 (about 12 hours of instruction).

Speakers: Lauren Franke, Psy.D., CCC-SLP was instrumental in the design and implementation of the AFA. She has been the main facilitator and lecturer. Her background as a licensed speech and language pathologist and clinical psychologist enabled her to address the complexity of conducting a comprehensive assessment, emphasizing an interdisciplinary approach. Her expertise in assessing and providing therapy is extensive. She integrated many resources and research-based practices into the AFA. Supplemental speakers were added to focus on "specialty" topics such as bilingual assessment, functional behavioral assessments, legal issues and the challenges of assessing students with significant deficits. AFA participants were also encouraged to attend sessions offered through the S.U.C.S.E.S.S. Project and Regional Center of Orange County. Often assessment issues, which lead to the determination of appropriate intervention, were addressed within their presentations.

Approximate numbers	Preschool/Elementary team members	Secondary team members
2004 – 05 Group A	118	57
2005 – 06 Group B	77	41
2006 – 07 Group C	89	56
2007 – 08 Group D	101	28
2008 - 09 Group E	76	16
Total	***461***	***198***

This year, the Orange County Special Education Alliance generously supported our efforts, allowing the participants to attend at no cost. These funds covered speakers' fees, printing and the cost of some substitutes if requested.

Results and future goals: The quality of assessments for students with ASD has greatly improved as reported by parents, administrators and outside agencies, such as Regional Center and For OC Kids. Staff evaluations from each session were reviewed and used to shape the series throughout the year. Comments reflected an increase in learning and application of skills in conducting comprehensive assessments and reports writing. Team dynamics were addressed. Opportunities to "problem solve" on tough cases (always honoring confidentiality issues) allow the participants to gain insights from each other. Many reported a real appreciation of the access to the most current information in the area of assessment.

In 2009-2010, the AFA will provide Tier 2 hours for Group E. In addition, we are designing an Advanced AFA Support series to provide more individualized technical assistance. Participants will "take the lead" in discussions and problem solving. Lauren Franke, and others, will be available to "mentor and coach" as the assessment process leads into determination of appropriate interventions and the IEP process.

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Thristan Mendoza's Success as a World-Class Marimba Musician

Thristan Mendoza, better known as "Tum-Tum" to his family and friends, is a world-class marimba musician.

Born in Quezon City in 1989, Tum-Tum was diagnosed with autism at the age of two and a half. His mother noted unusual behaviors, such as his dislike of video lights or any form of the shade of red. While Tum-Tum was fascinated with spinning objects such as electric fans and bicycle wheels, he could not bear the sounds of electric drills and food grinders. He was very shy and did not like to look at his mirror image. He repeated words over and over and needed a lot of prodding before joining other children.

His musical talent was discovered when his school ordered a psychological test, which showed an average Verbal IQ with superior Non-verbal IQ skills, autism and his musical skills.

Tum-Tum started to play three musical instruments all at the same time: drums, cymbals and temple block, and it all started the same year he was diagnosed with autism. He learned to play marimba at the age of five. After a few months, he found himself playing for the Philippine Madrigal Singers, in a concert on the main stage of the Theater of the Cultural Center of the Philippines as a special guest.

By the age of 10, he had performed 120 shows with musicians around the world.

Awards for an outstanding musician

Because of his excellent and world-class marimba skills, Tum-Tum has garnered many awards in the Phillipines and abroad. In March 2001, he received the Rosemary Kennedy International Young Soloist Award from the Very Special Arts. He was also invited to perform at the John F. Kennedy Center for the Performing Arts in Washington, D.C.

A year before, the Walt Disney Company, McDonald's Corporation and United Nations Educational, Scientific and Cultural Organization presented him the Millennium Dreamer's Award. This award is to honor children worldwide who contribut to their community by being an inspiration to youth.

He became the youngest person to be featured as a gifted child by the University of the Philippines. Tum-Tum is also the only 2-time grand prize awardee

of McDonald's Philippines Makabata Award.

Through the years, Tum-Tum managed to improve his musical skills, which continue to grow.

He is looking forward to the release of his first album soon with proceeds going to Autism Society Philippines' educational fund, which benefits families who cannot afford education and therapies for their children with autism.

Tum-Tum's musical talents have helped in raising the autism awareness in the Philippines and abroad. They have helped in the mission of Autism Society Philippines and other PWD sectors.

He has been described by news articles as **"having been born with a pair of sticks in his hands."**

His recent concert will convince audiences that autism and incredible talents often go hand in hand:
http://www.youtube.com/watch?v=tWGinEGg7sk

Adapted from an original article by:

Raphael D. Torralba
E-mail: raph_torralba@hotmail.com
In: www.withnews.com, May 31, 2009

a comment from our readers...

"ANOC is a great publication. I only wish it could be distributed more widely. I often send links to my students and to other researchers."

Let's do this together

By Sawanizah Mohd. Said

Jack (on the left) is a 6-year-old boy diagnosed with mild autism who has a younger sister, Jill (4 years old) who is diagnosed with severe autism. He has learned to care and "protect" his sister as their parents have inculcated a "big brother role" for him, which he performs very well. He even started to be a "big brother" to other younger children at the Autism Center for Children. EJ, a 5-year-old boy diagnosed with moderate autism, is one of the younger friends Jack is looking out for. We observed that EJ, who is normally reserved and passive, would try new or challenging activities when Jack is with him. In this photo, Jack leads EJ into the water playground. Facing challenges is easier when you have a friend at your side.

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The ever-changing life with my son, Zane

Now ... if you will allow me the honor, let me say a few things about living with autism from 2004 to the present day.

I am a preschool educator. I am not stupid. I could see that Zane was different since he was a little more than one. We were all rejoicing far too early when we heard him utter his first word, "papa," in the car when he was 8 months old. I wondered why Zane didn't say more words after that, you know, even the very basic words like "mum mum," "ball," "go," and "bye." He never waved anyone goodbye. He never blew kisses like all toddlers do. He never did the usual things that boys his age did.

One thing we remember vividly is that Zane was a very difficult baby and toddler. Bringing him places was very challenging. I didn't dare venture alone with two children then. Once, we attended a dear friend's daughter's first birthday. Zane was very overwhelmed and had sensory overload (of which I was not aware). I wanted to cry there and then but I held back my tears of frustration until late that night after all were asleep. I told myself then, "No more parties for Zane. No more other people's houses for Zane when I am alone. No more ... ."

I placed him in a playgroup to test my suspicion. Two days was all that I needed to know that my boy is different from his peers.

Zane turned two while we waited for an assessment date. It was a really looooooong wait. At more than three years old, he was finally granted an audience with the Authority in this field. Just a few glances at him and a few questions and she deduced that he is autistic and announced that he would be put through their diagnostic testing to confirm it.

I walked out of the clinic that fateful day shocked. "Another round?" was all that was flashing through my mind, back and forth.

I went through what the experts in this field called:

Stage One: When first diagnosed, "disbelief."

All of a sudden, just the way bubbles burst within seconds, my dream and hope that my son would talk and learn with me vanished. My vision that we could send him to the same preschool as Zoe also disappeared.

"I think he is between moderately and severely autistic."

"Autism has no cure."

"You may want to consider putting him in a special school."

These statements from the Authority pierced and broke the person in me. All of a sudden I felt inadequate and lost, despite my years of training in childhood education. Friends who know me know that I am a very self-assured and confident woman. But all that was gone the moment I stepped out of those cold doors. I knew that I would become a different person from that day forth. And so I did.

I went into the next stage.

Stage Two: The "hope" emerged as the Pediatrician said OT, ST, ABA, etc. will help when started at a young age. At this stage, there are also signs of non-acceptance.

"How can my son be in an autism centre for the next 2-6 years?" "Why can't he attend the same preschool as his sister?"

I searched for a childcare center that offered integrated programs right from the start. No need to try the mainstream Kindergartens, Zane would surely be shown the exit door within the first 3 hours.

The childcare Zane attended has the integrated program but alas, not all the teachers there are trained to handle special needs children. If Zane's teachers were willing to take the time and effort to understand him and work around him, that was already half the battle won. If the same teachers observed how the therapists I hired managed him and helped him through the classroom routines by modeling or modifying? That was really HUGE, HUGE blessings dropped from heaven into our laps. Zane had both!!

He always had very loving teachers in his more than two year stay at the centre. Thank you, dear teachers, if you are reading this article now. You don't know how

much your help, dedication and willingness to embrace Zane helped me to survive the darkest days of parenting. When Zane was with you, I had peace of mind knowing that he would be well taken care of. Even on bad days, I knew you ladies would go the extra mile with him. I know my boy made you cry and made you smile at the same time. I know my boy has left very deep footprints in your teaching career. I know he will be one student you will never forget because of the fights he had with you on the floor. Thank you ... with tears ....

We engaged a private therapist to come to Zane's school to do sessions with him. His school converted a space into a therapy room with a one-way mirror. That way any teacher who wanted to observe the sessions without distracting Zane could view the sessions through the glass. I am very grateful to the centre's supervisor, who pushed for this idea and had it created.

Subsequently more and more of the ASD children in the centre benefited from this concept. Eventually, the school ventured into providing these in-house therapy sessions. Zane was enrolled among its first batch of students. The program was proven effective, as the therapist was skilful and confident. Zane's teachers who were willing to learn from the therapist, eventually managed to take Zane's behavior in stride. This is what we call generalization and inclusion. My son was very blessed. He always had great, dedicated teachers.

Concurrently with his childcare's in-house IEP program, Zane also attended the Autism Children's Centre's (ACC) twice weekly Early Intervention program. At times he would have two sessions a day. Poor boy, by 3 p.m. he was super tired.

Zane's two years with ACC was also beneficial for him. He was matched to the right therapist at the right stage of his development and needs. ACC has only 2 male therapists in their whole organization and Zane was very blessed to have them both! I am very indebted to these teachers. I felt bad that Zane struggled so hard with them, knocking them over at times and sometimes physically hurting them with his abrupt actions and tantrums. I'm sorry, teachers, that you had to put up with this aspect of my son's behavior week after week.

I was especially touched when the Program Head mentioned to me that after Zane's graduation ceremony on the last day of March, she had to time herself in her office (on the pretext that she had to return some calls and before lunch.) to have a hearty cry. That she had seen that four-year-old boy grow to the six-year-old boy she just sent out of her centre filled her kind soul with many tears, joy and comfort. Thank you, N.! My family is another you have touched through your passion and love for our special children. I wish you all the best in all that your hands set to do, be it for yourself or for others. God bless you always.

This is getting too heavy for me. I need to stop here and rest my heart. I will continue ... no promises though.

Zane's Mum, Singapore

Adapted with kind permission from blog at: jjzzj.wordpress.com.

Thank You For Your Support!

The following donations for ANOC have recently been received through the Autism Support Fund.

We very much appreciate all the support!

Supporter ($1,000-$2,999)

Christina McReynolds

REACT Foundation

Contributor ($500-$999)

Vera Bernard-Opitz

Friend ($25-$499)

Janis White

David Monkarsh

Michael & Suzanne Pugsley

Joseph DeCarlo, JD Property Management

Anonymous

Stuart Krassner

Geeta Grover

Dr. William H. Murphey, III

Wiltrud & Gottfried Luderer

S.H. Annabel Chen

Your support is urgently needed to help ANOC continue. Please consider a donation today through www.autismnewsoc.org today.

Thank you!

Recreation Resource Guide:

RCOC and Comfort Connection Family Resource Center

Not Just for Summer Fun

Here in Orange County, there is no shortage of fun things to do. There are many social and recreational opportunities for children and adults with autism. The Regional Center of Orange County and Comfort Connection Family Resource Center have developed a FREE Recreation Resource Guide, which lists many activities including sports, arts and camping. There is also a section with additional opportunities outside of Orange County. You can obtain a copy of this guide by visiting the Family Support link at www.rcocdd.com or by calling Comfort Connection Family Resource Center at (714) 558-5400.

REGIONAL CENTER OF ORANGE COUNTY

COMFORT CONNECTION FAMILY RESOURCE CENTER

USEFUL LINKS

The Grandparent Autism Network's web site, www.ganinfo.org, has posted new videos, including **"Today's Autism Research: Tomorrow's Promising Outcomes."** This video was recorded at the third annual *Autism Research Conference*, presented on January 31, 2009. Visit the GAN website for more details.

a few kind comments from our readers...

"ANOC provides a critical conduit for information regarding intervention and support services for individuals with autism spectrum disorders."

♥

"I look forward to getting my ANOC – it is the only newsletter I actually read and it is the best out there. It is sent to professionals all across the world. It would be a great loss if it is no longer funded."

♥

"It is a valuable resource for families and professionals in the field of autism."

♥

"Love it, clients in the waiting room love it and we keep old issues out for their review."

♥

"Outstanding, well researched, informative and helpful to families."

♥

"I always find [ANOC] interesting to read - it gives a useful update on practical research conducted in the U.S. and beyond."

♥

"ANOC is an extremely well edited, informative journal. It deals with important issues not easily found in other journals. It is a very valuable resource for new and sometimes different ideas, in typically very thoughtful and thought provoking articles."

♥

"ANOC provides excellent practical advice for teachers and parents on ways to foster the development of children with ASD. It is an invaluable publication that successfully bridges the all too formidable gap between academic research and everyday practice."

"I have used ANOC with both staff and parents as a resource."

♥

"An excellent contribution to the field."

♥

"The articles published are of high quality, relevant to practitioners, as they provide practical teaching ideas as well as the latest research developments and application of effective interventions."

♥

"Thank you for this publication. It's been a help to me as a new parent on this journey. Also I was not aware of the website. I am very excited to check it out."

♥

"ANOC is a wonderful resource for patients, families, and service providers. It is not only educational, but a great way to link into other support systems and programs."

♥

"ANOC is a wonderful service to families and professionals in the area and beyond."

AUTISM NEWS
of Orange County
& the Rest of the World

WE NEED YOUR SUPPORT

To continue our newsletter, we need your support. Please donate now at
http://autismnewsoc.org/donation.php

Upcoming Staff Development, Conferences and Parent Trainings

PLEASE NOTE: This is a partial listing as of June 4, 2009 and subject to change. More details will be posted on our website after August 2009. For more current updated information, visit us online at http://sped.ocde.us/cses/Autism/cc_ap/sd/cbs.htm.

Throughout the school year, there are several opportunities for continuing education and support that will be offered by various organizations, however during these summer months, the offerings are more limited.

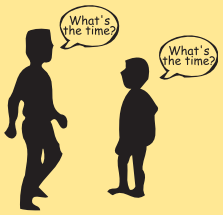
The **Regional Center of Orange County** (RCOC) and the **S.U.C.S.E.S.S. Project of Orange County** strives to provide affordable fees to both families and staff. Each session has a specific focus, some pertaining to early interventions, some with more of an emphasis on the older aged student. **Registrations for those outside of Orange County may be limited, therefore call early!**

Date/Time/Place	Topic/Speaker	Developmental Level	Approximate Fee	Contact
Sept. 17, 2009 8:30 AM – 3:30 PM OCDE	"Social Thinking – I LAUGH Model" (Day 1/3) *Michelle Garcia Winner*	Developmental Ages 8+	$65	S.U.C.S.E.S.S. Project (714) 966-4198
Sept. 18, 2009 8:30 AM – 3:30 PM OCDE	OVERVIEW "Social Thinking & Curriculum Implementation" (Day 5) *Michelle Garcia Winner*	Developmental Ages 8+	$65	S.U.C.S.E.S.S. Project (714) 966-4198
Sept. 25, 2009 8:30 AM – 3:30 PM OCDE	Use of Narratives for Language & Social Development *Lauren Franke, Ph.D.*	All Ages	$65	S.U.C.S.E.S.S. Project (714) 966-4198
Oct. 12, 2009 8:30 AM – 3:30 PM OCDE	Icon to I Can– Using Visual Supporters and Strategies *Barbara Bloomfield*	Early- to middle-age developmental levels	$65	S.U.C.S.E.S.S. Project (714) 966-4198
Nov. 6, 2009 8:30 AM – 3:30 PM OCDE	The Role and Responsibilities of the Special Education Paraeducator *Kent Gerlach*	All Ages	$65	S.U.C.S.E.S.S. Project (714) 966-4198
Nov. 17, 2009 4:00 PM – 8:00 PM RCOC	"Bullying: How does a parent respond?" *Diane Twachtman-Cullen*	All Ages	$30	RCOC Karen Schaeffer (714) 796-5330
Feb. 24, 2010 8:30 AM – 3:30 PM Location TBA	"Social Thinking – I LAUGH Model – Looking into the mind of ASD" (Day 6) *Michelle Garcia Winner*	Developmental Ages 8+	$65	S.U.C.S.E.S.S. Project (714) 966-4198
Feb. 25, 2010 8:30 AM – 3:30 PM Location TBA	OVERVIEW "Social Thinking & Organizational Skills – Teaching beyond the THINK social curriculum" (Day 7) *Michelle Garcia Winner*	Developmental Ages 8+	$65	S.U.C.S.E.S.S. Project (714) 966-4198
May 4, 2010 8:30 AM – 3:30 PM OCDE	Transition Issues– Adolescence into Adulthood *Peter Gerhardt, Ed.D.*	Middle elementary- to secondary-aged students	$65	S.U.C.S.E.S.S. Project (714) 966-4198

Locations: ***OCDE*** = *Orange County Department of Education – 200 Kalmus Drive, Costa Mesa, CA 92628* ***RCOC*** = *Regional Center of Orange County – 801 Civic Center Drive West, Santa Ana, CA 92702*

SOME EXAMPLES OF AUTISTIC BEHAVIOR
ALGUNOS EJEMPLOS DEL COMPORTAMIENTO DE PERSONAS CON AUTISMO

Avoids eye contact
Evita el contacto visual



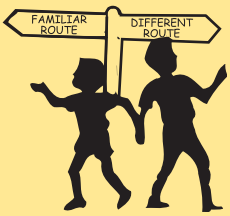
Copies words like a parrot ("echolalic")
Repíte las palabras como un loro ("en forma de echo")

Shows preoccupation with only one topic
Demuestra preocupación/interés en solo un tema/asunto

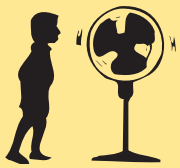
Lacks creative "pretend" play
Carece el juego creativo

Shows indifference
Demuestra indiferéncia

Displays special abilities in music, art, memory, or manual dexterity
Demuestra capacidades especiales en musica, arte, memoria or destreza manual



Does not like variety: it's not the spice of life
No demuestra interés en variedad



Shows fascination with spinning objects
Demuestra fascinación con objetos que gíran

Shows fear of, or fascination with certain sounds
Demuestra miedo de/ó fascinación con ciertos sonidos

Laughs or giggles inappropriately
Risa/reír inadecuadamente

Shows one-sided interaction
Demuestra interacción que es unilateral

Some Examples of Autistic Behavior
Algunos ejemplos del comportamiento de personas con autismo

- Difficulty with social interactions.
  Tienen dificultad para socializar con otras personas.
- Problems with speech.
  Tienen problemas con su lenguaje.
- Disturbed perception.
  Tienen una percepción anormal de los sucesos que acontecen a su alrededor.
- Abnormal play.
  Su forma de jugar es anormal.
- Resistance to change in routine or environment.
  Se resisten a cambios en sus actividad rutinarias ó a su medio ambiente.

Does not play with other children
No juega con otros niños