**Recognising Autism and considering diagnostic assessment: a short guide**

**Introduction**

Autism probably affects around 1% of the population. It is associated with a higher chance of both physical and mental health problems. It is therefore important to try and identify it as early as possible. However, it is a complex condition and diagnostic assessment can be lengthy and intrusive. It is therefore also important not to put children through the process without good reason.

The diagnosis requires that an individual has pervasive difficulties in areas like communication, interaction, play, friendships, emotions and behaviour. So Autism assessment will not be appropriate for anyone with needs in only one or two areas. It is a specialist assessment that would usually take place after assessments by other services (e.g. Speech and Language Therapy (SLT), Occupational Therapy (OT), Child and Adolescent Mental Health Services (CAMHS), Paediatrics, Learning Disability (LD), Educational Psychology (EP) or the Communication and Interaction Team (CAIT).

Whilst it may seem sensible to refer for Autism assessment at the earliest opportunity, it is usually better for children to be assessed first by these single agencies, so they receive interventions and supports as their needs arise. Immediate referral for Autism assessment may mean they miss or get delayed access to these supports. For example, a socially anxious child with a language impairment would not benefit from having an Autism assessment before they receive assessment and intervention from SLT and CAMHS.

We therefore want the Autism assessment pathway to be accessible. This short guide is intended to outline the basic characteristics of Autism Spectrum Disorder (ASD) to ensure that people can recognise and identify the signs. We hope it will help you decide when to refer for ASD assessment and when to request other types of assessment.

**What does ASD look like? Signs of ASD in school-aged children[[1]](#footnote-1)**

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| **Spoken language*** preferring to avoid using spoken language
* speech that sounds very monotonous or flat
* using pre-learned phrases, rather than making new sentences
* talking "at" people, rather than sharing in two-way conversation
* responses to others may seem rude, tactless or inappropriate

**Responding to others*** taking people’s speech literally and being unable to understand sarcasm, metaphors or figures of speech
* unaware of or not responding to feelings or intentions of others
* reacting negatively when asked to do something by others

**Interacting with others*** not being aware of other people’s personal space, or being intolerant of people entering their own personal space
* avoiding or having no interest in peer relationships, or having few close friends, despite attempts to form friendships
* unusual behaviours when greeting people or saying goodbye
* not adapting to different social situations – for example, being formal at a party, or approaching total strangers in a familiar way
* not enjoying free time or play situations that most peers enjoy
* rarely using gestures or facial expressions when communicating
* avoiding eye contact
* sticking to their own agenda

**Restricted Interests and Repetitive Behaviour*** repetitive movements, such as flapping their hands, rocking back and forth, or flicking their fingers
* playing in a repetitive and unimaginative way, often preferring to play with objects rather than people
* having very limited interests, and/or developing a highly specific interest in a particular subject or activity
* preferring to have a familiar routine and getting very upset if there are changes to their normal routine
* reacting negatively to changes in their environment
* having a strong like or dislike of certain foods based on the texture or colour of the food as much as the taste
* unusual sensory interests – for example, children with ASD may sniff toys, objects or people inappropriately
* over or under reaction to sensory stimuli (e.g. sounds, smells, textures, tastes)
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**Information for referrers:**

Please consider the information below as it will help ensure that you avoid common pitfalls. If you are referring your child, or yourself, then please feel free to contact us by e-mail or phone on 0330 024 5321 (Single Point of Access). Some of the concepts involved may not be easy to understand but we’re happy to help if you get in touch.

**Common pitfalls:**

We cannot accept referrals without the consent of the individual or their parent or guardian.

The most common reasons why we can’t accept referrals are:

1. Insufficient evidence of needs, or evidence of one need only.
2. There are multiple needs, but these are EITHER social communication difficulties OR rigid or repetitive behaviours and we need evidence of both
3. The needs have only recently appeared, and there is no evidence of persisting difficulty
4. There is no evidence of the concerns having an impact on the individual’s day to day life.

The best way to avoid these pitfalls is to ensure that the individual’s basic needs are assessed by schools and core services in a timely way. Referrals of individuals who have never been seen by other services (e.g. SLT, Paediatrics, LD, EP, CAIT, CAMHS, OT etc.) may be less likely to be accepted.

Autism is a complex condition with some quite subtle presentations, and we therefore accept referrals from anyone. It isn’t essential to have been seen by other services, but it is helpful if this information is available. In addition, it’s important that anyone considering a referral knows they can contact us directly to discuss things in person.

**What counts as evidence?**

We are looking for evidence that needs have been identified and that supports have been put in place. We’d like descriptions of the difficulties themselves and how they have responded to support. The easiest way to provide us with this evidence is sharing completed Devon Graduated Response tool (DGR) paperwork. DAF (Devon Assessment Framework) paperwork may be accepted if this has been completed. We will request DGR paperwork from schools for all referrals.

Referrers from services other than schools should include their assessments, details of the supports and interventions that have been tried, ASD signs and symptoms and their impact, and an outline of how ASD assessment will benefit the individual. We expect the referrer to remain involved and support our assessment process.

**What happens to referrals we cannot accept?**

If there is limited evidence of need or impact, then we will return the referral and provide guidance about referring for Autism assessment. We will consider re-referrals if sufficient evidence is provided.

If there is evidence of needs but these are not suggestive of Autism (e.g. there’s only one need, or the needs described appear temporary) then we may pass the referral on for a single agency assessment. If we pass a referral onto another agency, and they feel after intervention that Autism assessment is appropriate, then that service will make the referral and provide the necessary evidence for this.

**More detail for referrers**

Four criteria are necessary for a diagnosis of ASD:

1. Lifelong symptoms
	* Do not refer for concerns which are recent or temporary. The symptoms of ASD may not always be obvious, and in some cases will be actively hidden or ‘masked’. Careful questioning may be required in order to identify some of these symptoms, but it is a lifelong condition and should not be considered where concerns are temporary or recent.
2. Difficulties communicating and interacting socially
	* A number of conditions can lead to social difficulties. For ASD we need to show a persistent failure to sustain meaningful social relationships appropriate to the individual’s developmental ability. If social difficulties are the only concern, then consider a referral for SLT, social anxiety or educational needs rather than ASD.
3. Restricted interests and rigid or inflexible behaviours
	* Repetitive patterns of behaviour, obsessional interests and preoccupations, a limited range of interests, difficulties coping with change – all of these things can be suggestive of ASD but only if the other three criteria are also met. If this is the only concern, then consider a referral to OT, Children with Additional Needs (CAN) or CAMHS.
4. Impact on everyday functioning
	* As with any diagnosis, the difficulties need to be having an impact on the individual’s day to day quality of life, and/or on the lives of those people they live with. The diagnosis cannot be made in the absence of clear evidence of impact.

ASD is a pervasive condition and the assessment requires multi-agency collaboration. We respond to referrals by requesting reports and opinion from relevant agencies, including education, social care, and a variety of services within Children and Family Health Devon. It is the responsibility of workers across all agencies to acquire skills in the identification of possible ASD, but also to learn when it is appropriate to refer and when it is not. We hope you have found this guide useful, and welcome feedback on it from you.

Last reviewed: 11th May 2020

1. Adapted from NICE guideline on ASD. See [*https://www.nhs.uk/conditions/autism/symptoms/*](https://www.nhs.uk/conditions/autism/symptoms/) *for more detailed information on identifying ASD in children at different ages* [↑](#footnote-ref-1)