Identifying and Screening Autism at School

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Acknowledgement
Adapted from...

Lecture Outline
- Introduction: Reasons for Increased Vigilance
- Diagnostic Classifications and Special Education Eligibility
- School Psychologist Roles, Responsibilities, and Limitations
- Case Finding
- Screening and Referral

Introduction: Reasons for Increased Vigilance
- Autistic spectrum disorders are much more common than previously suggested.
  - 60 (vs. 4 to 6) per 10,000 in the general population (Chakrabarit & Fombonne, 2001).
  - 600% increase in the numbers served under the autism IDEA eligibility classification (U.S. Department of Education, 2003).
  - 95% of school psychologists report an increase in the number of students with ASD being referred for assessment (Kohrt, 2004).

Explanations for Changing ASD Rates in the General Population
- Changes in diagnostic criteria.
- Heightened public awareness of autism.
- Increased willingness and ability to diagnose autism.
- Availability of resources for children with autism.
- Yet to be identified environmental factors.

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**Increased Prevalence in Special Education (U.S. Department of Education, 2003)**

Student Classified as Autistic Under IDEA as a Percentage of all Students with Disabilities: 1994 to 2003

**Explanations for Changing ASD Rates in Special Education**

- Classification substitution
  - IEP teams have become better able to identify students with autism.
  - Autism is more acceptable in today's schools than is the diagnosis of mental retardation.
  - The intensive early intervention services often made available to students with autism are not always offered to the child whose primary eligibility classification is mental retardation.

**Increased Prevalence in Special Education (U.S. Department of Education, 2003)**

Percentage of Students Classified as Autistic or Mentally Retarded Under IDEA as a Percentage of all Students with Disabilities: 1994 to 2003

**Reasons for Increased Vigilance**

- Autism can be identified early in development, and...
- Early intervention is an important determinant of the course of autism.

**Reasons for Increased Vigilance**

- Not all cases of autism will be identified before school entry.
  - Average Age of Autistic Disorder identification is 5 1/2 years of age.
  - Average Age of Asperger's Disorder identification is 11 years of age (Howlin and Asgharian, 1999).

**Reasons for Increased Vigilance**

- Most children with autism are identified by school resources.
  - Only three percent of children with ASD are identified solely by non-school resources.
  - All other children are identified by a combination of school and non-school resources (57 %), or by school resources alone (40 %) (Yeargin-Allsopp et al. 2003).
Reasons for Increased Vigilance

- Full inclusion of children with ASD in general education classrooms.
  - Students with disabilities are increasingly placed in full-inclusion settings.
  - In addition, the results of recent studies suggesting a declining incidence of mental retardation among the ASD population further increases the likelihood that these children will be mainstreamed (Chakrabarti & Fombonne, 2001).
  - Consequently, today’s educators are more likely to encounter children with autism during their careers.

Evolution of the Term “Autism”

- First used by Swiss psychiatrist Eugen Bleuler in 1911.
  - Derived from the Greek autos (self) and ismos (condition), Bleuler used the term to describe the concept of “turning inward on ones self” and applied it to adults with schizophrenia.
- In 1943 Leo Kanner first used the term “infantile autism” to describe a group of children who were socially isolated, were behaviorally inflexible, and who had impaired communication.
- Initially viewed as a consequence of poor parenting, it was not until the 1960’s, and recognition of the fact that many of these children had epilepsy, that the disorder began to be viewed as having a neurological basis.

Evolution of the Term “Autism”

- In 1980, infantile autism was first included in the third edition of the Diagnostic and Statistical Manual (DSM), within the category of Pervasive Developmental Disorders.
- Also occurring at about this time was a growing awareness that Kanner’s autism (also referred to a classic autism) is the most extreme form of a spectrum of autistic disorders.
- Autistic Disorder is the contemporary classification used since the revision of DSM’s third edition (APA, 1987).

Diagnostic Classifications

In this workshop the terms “Autism,” or “Autistic Spectrum Disorders (ASD)” will be used to indicate these PDDs.

<table>
<thead>
<tr>
<th>Pervasive Developmental Disorders</th>
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<tbody>
<tr>
<td>Autistic Disorder</td>
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<tr>
<td>Asperger’s Disorder</td>
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<tr>
<td>PDD-NOS</td>
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<tr>
<td>Rett’s Disorder</td>
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<tr>
<td>Childhood Disintegrative Disorder</td>
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</tbody>
</table>

Diagnostic Classifications

- Autistic Disorder
  - Markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests.
- Asperger’s Disorder
  - Markedly abnormal or impaired development in social interaction and a markedly restricted repertoire of activities and interests (language abilities and cognitive functioning is not affected).
- PDD-NOS
  - Experience difficulty in at least two of the three autistic disorder symptom clusters, but do not meet diagnostic criteria for any other PDD.
Diagnostic Classifications

- **Rett's Disorder**
  - Occurs primarily among females and involves a pattern of head growth deceleration, a loss of fine motor skill, and the presence of awkward gait and trunk movement.

- **Childhood Disintegrative Disorder**
  - Very rare. A distinct pattern of regression following at least two years of normal development.

Special Education Eligibility:

**Proposed IDEA Regulations**

- **IDEIA 2004 Autism Classification**
  - P.L. 108-446, Individuals with Disabilities Education Improvement Act (IDEIA), 2004
  - Proposed USDOE Regulations for IDEA 2004 [§ 300.8(c)(1)]
    - Autism means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, that adversely affects a child's education performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotypical movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences. (i) Autism does not apply if a child's educational performance is adversely affected primarily because the child has an emotional disturbance, as defined in paragraph (c)(4) of this section. (ii) A child who manifest the characteristics of autism after age three could be identified as having autism if the criteria in paragraph (c)(1)(i) of this section are satisfied.

**Current California Regulations**

- **CA Autism Classification**
  - Title 5, CCR 3030(g):
    - A pupil exhibits any combination of the following autistic-like behaviors, to include but not limited to: (1) an inability to use oral language for appropriate communication; (2) a history of extreme withdrawal or relating to people inappropriately and continued impairment in social interaction from infancy through early childhood; (3) an obsession to maintain sameness; (4) extreme preoccupation with objects or inappropriate use of objects or both; (5) extreme resistance to controls; (6) displays peculiar motoric mannerisms and motility patterns; (7) self-stimulating, ritualistic behavior.

Special Education Eligibility

**For special education eligibility purposes distinctions among PDDs may not be relevant.**

- While the diagnosis of Autistic Disorder requires differentiating its symptoms from other PDDs, Shriver et al. (1999) suggest that for special education eligibility purposes “the federal definition of ‘autism’ was written sufficiently broad to encompass children who exhibit a range of characteristics” (p. 539) including other PDDs.

**However, it is less clear if students with milder forms of ASD are always eligible for special education.**

- Adjudicative decision makers almost never use the DSM IV-TR criteria exclusively or primarily for determining whether the child is eligible as autistic” (Fogt et al., 2003).
- While DSM IV-TR criteria are often considered in hearing/court decisions, IDEA is typically acknowledged as the “controlling authority.” When it comes to special education, it is state and federal education codes and regulations (not DSM IV-TR) that drive eligibility decisions.

Legal Information

- For additional information...
Lecture Outline

School Psychologist Roles, Responsibilities, and Limitations

1. School psychologists need to be more vigilant for symptoms of autism among the students that they serve, and better prepared to assist in the process of identifying these disorders.

School Psychologist Roles, Responsibilities, and Limitations

2. Case Finding
   - All school psychologists should be expected to participate in case finding (i.e., routine developmental surveillance of children in the general population to recognize risk factors and identify warning signs of autism).
     - This would include training general educators to identify the risk factors and warning signs of autism.

School Psychologist Roles, Responsibilities, and Limitations

3. Screening
   - All school psychologists should be prepared to participate in the behavioral screening of the student who has risk factors and/or displays warning signs of autism (i.e., able to conduct screenings to determine the need for diagnostic assessments).
   - All school psychologists should be able to distinguish between screening and diagnosis.

4. Diagnosis
   - Only those school psychologists with appropriate training and supervision should diagnose a specific autism spectrum disorder.

School Psychologist Roles, Responsibilities, and Limitations

5. Special Education Eligibility
   - All school psychologists should be expected to conduct the psycho-educational evaluation that is a part of the diagnostic process and that determines educational needs.
   - NOTE:
     - The ability to conduct such assessments will require school psychologists to be knowledgeable of the accommodations necessary to obtain valid test results when working with the child who has an ASD.

Lecture Outline

- Introduction: Reasons for Increased Vigilance
- Diagnostic Classifications and Special Education Eligibility
- School Psychologist Roles, Responsibilities, and Limitations
- Case Finding
- Screening and Referral
Identifying and Screening Autism at School

**Case Finding**

- **Looking**
  - for risk factors and warning signs of atypical development.

- **Listening**
  - REALLY LISTENING to parental concerns about atypical development.

- **Questioning**
  - caregivers about the child’s development.

**Case Finding: Looking for Risk Factors**

- **Known Risk Factors**
  - **High Risk**
    - Having an older sibling with autism.
  - **Moderate Risk**
    - The diagnosis of tuberous sclerosis, fragile X, or epilepsy.
    - A family history of autism or autistic-like behaviors.

**Case Finding: Looking for Risk Factors**

- Currently there is no substantive evidence supporting any one non-genetic risk factor for ASD.
- However, given that there are likely different causes of ASD, it is possible that yet to be identified non-heritable risk factors may prove to be important in certain subgroups of individuals with this disorder.
  - There may be an interaction between the presence of specific genetic defects and specific environmental factors.
  - Individuals with a particular genetic predisposition for ASD may have a greater risk of developing this disorder subsequent to exposure to certain non-genetic risk factors.
  - In particular, it has been suggested that prenatal factors such as maternal infection and drug exposure deserve further examination.

**Case Finding: Looking for Warning Signs**

- **Infants and Preschoolers**
  - Absolute indications for an autism screening
    - No big smiles or other joyful expressions by 6 months.\(^b\)
    - No back-and-forth sharing of sounds, smiles, or facial expressions by 9 months.\(^b\)
    - No back-and-forth gestures, such as pointing, showing, reaching or waving bye-bye by 12 months.\(^a,b\)
    - No babbling at 12 months.\(^a,b\)
    - No single words at 16 months.\(^a,b\)

- **School-Age Children (preschool through upper grades)**

**Sources:** aFilipek et al., 1999; bGreenspan, 1999; and cOzonoff, 2003.
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Case Finding: Looking for Warning Signs

Case Finding: Looking for Warning Signs

Case Finding: Looking for atypical development

Case Finding: Looking for atypical development

Case Finding: Listening to caregivers

Case Finding: Listening to caregivers

School-Age Children (preschool through upper grades)

Communication Concerns

- Unusual tone of voice or speech (seems to have an accent or monotone, speech is overly formal)
- Overly literal interpretation of comments (confused by sarcasm or phrases such as “pull up your socks” or “looks can kill”)
- Atypical conversations (one-sided, on their focus of interest or on repetitive/unusual topics)
- Poor nonverbal communication skills (eye contact, gestures, etc.)

School-Age Children (preschool through upper grades)

Behavioral Concerns

- Excessive fascination/perseveration with a particular topic, interest or object
- Unduly upset by changes in routines or expectations
- Tendency to flap or rock when excited or distressed
- Unusual sensory responses (reactions to sound, touch, textures, pain tolerance, etc.)
- History of behavioral concerns (inattention, hyperactivity, aggression, anxiety, selective mute)
- Poor fine and/or gross motor skills or coordination

Developmental Screening

- Ages and Stages Questionnaire
  - Paul H. Brookes, Publishers
- Child Development Inventories
  - Behavior Science Systems
- Parents’ Evaluations of Developmental Status
  - Ellsworth & Vandermeer Press, Ltd.

Staff Development

- School psychologist efforts to educate teachers about the risk factors and warning signs of ASD would also be consistent with Child Find regulations [see 17 CCR 52040(b)(7)]. Giving teachers the information they need to look for ASD (such as is presented in this workshop) will facilitate case finding efforts.

Referring Concerns That Signal the Need for Autism Screening

- Social Concerns
  - Does not smile socially
  - Seems to prefer to play alone
  - Is very independent
  - Has poor eye contact
  - Is in his/her own world
  - Tunes us out
  - Is not interested in other children

Case Finding: Listening to caregivers

- Referring Concerns That Signal the Need for Autism Screening
  - Behavioral concerns
    - Tantrums
    - Is hyperactive or uncooperative/oppositional
    - Doesn’t know how to play with toys
    - Does the same thing over and over
    - Toe walks


Case Finding: Listening to caregivers

- Referring Concerns That Signal the Need for Autism Screening (continued)
  - Behavioral concerns
    - Has unusual attachments to toys (e.g., always is holding a certain object)
    - Lines things up
    - Is oversensitive to certain textures or sounds
    - Has odd finger and/or body movement patterns


Case Finding: Questioning caregivers

- Asking about socialization that probe for issues that would signal the need for an autism screening.
  - “Does s/he …” or “Is there …”
    - cuddle like other children?
    - look at you when you are talking or playing?
    - smile in response to a smile from others?
    - engage in reciprocal back-and-forth play?
    - play simple imitation games, such as pat-a-cake or peek-a-boo?
    - show interest in other children?


Case Finding: Questioning caregivers

- Asking about communication that probe for issues that would signal the need for an autism screening.
  - “Does s/he …” or “Is there …”
    - point with his/her finger?
    - gesture? Nod yes and no?
    - direct your attention by holding up objects for you to see?
    - anything odd about his/her speech?
    - show things to people?


Case Finding: Questioning caregivers

- Asking about behavior that probe for issues that would signal the need for an autism screening (continued).
  - “Does s/he …” or “Is there …”
    - lead an adult by the hand?
    - give inconsistent response to his/her name? … to commands?
    - use rote, repetitive, or echolalic speech?
    - memorize strings of words or scripts?


Case Finding: Questioning caregivers

- Asking about behavior that probe for issues that would signal the need for an autism screening.
  - “Does s/he …” or “Is there …”
    - have repetitive, stereotyped, or odd motor behavior?
    - have preoccupations or a narrow range of interests?
    - attend more to parts of objects (e.g., the wheels of a toy car)?
    - have limited or absent pretend play?
    - imitate other people’s actions?
    - play with toys in the same exact way each time?
    - strongly attached to a specific unusual object(s)?

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Screening and Referral

- Screening is designed to help determine the need for additional diagnostic assessments.
- In addition to the behavioral screening (which at school should typically be provided by the school psychologist), screening should include medical testing (lead screening) and a complete audiological evaluation.

Behavioral Screening of Infants and Preschoolers

- Checklist for Autism in Toddlers (CHAT)

Behavioral Screening of Infants and Preschoolers

- Checklist for Autism in Toddlers (CHAT)


- Case Found
  - Screening Indicated
  - No
  - Continue to monitor development
  - Autism Indicated
  - Refer for assessment as indicated
  - Diagnostic Assessment
  - Psych-educational Assessment
Behavioral Screening of Infants and Preschoolers

- **CHAT (Checklist for Autism in Toddlers)**
  - Designed to identify risk of autism among 18-month-olds
  - Takes 5 to 10 minutes to administer
  - Consists of 9 questions asked of the parent and 5 items that are completed by the screener’s direct observation of the child.
  - 5 items are considered to be “key items.” These key items assess joint attention and pretend play.
  - If a child fails all five of these items they are considered to be at high risk for developing autism.

**CHAT Section A: History**

1. Does your child enjoy being swung, bounced on your knee, etc.? YES NO
2. Does your child take an interest in other children? YES NO
3. Does your child like climbing on things, such as up stairs? YES NO
4. Does your child enjoy playing peek-a-boo/hide-and-seek? YES NO
5. Does your child ever pretend, for example to make a cup of tea using a toy cup and teapot, or pretend other things? YES NO
6. Does your child ever use his/her index finger to point to ask for something? YES NO
7. Does your child ever use his/her index finger to point to indicate interest in something? YES NO
8. Can your child play properly with small toys (e.g., cars or bricks) without just mouthing, fiddling or dropping them? YES NO
9. Does your child ever bring objects over to you (parent) to show your something? YES NO

**CHAT Section B: General Practitioner or Health Visitor Observation**

i. During the appointment, has the child made eye contact with you? YES NO
ii. Get child’s attention, then point across the room at an interesting object and say ‘Oh look! There’s a [name of toy]’. Watch child’s face. Does the child look across to see what you are pointing at? YES NO
iii. Get the child’s attention, then give the child a miniature toy cup and teapot and say ‘Can you make a cup of tea?’. Does the child pretend to pour out tea, drink it, etc.? YES NO
iv. Say to the child ‘Where is the light?’, or ‘Show me the light’. Does the child point with his/her index finger at the light? YES NO
v. Can the child build a tower of bricks? (If so how many?)

Scoring:
- **High risk for Autism**: Fails A5, A7, Bii, Biii, and Biv
- **Medium risk for Autism group**: Fails A7, Biv (but not in maximum risk group)
- **Low risk for Autism group (not in other two risk groups)**

M-CHAT (Modified Checklist for Autism in Toddlers)

- Designed to screen for autism at 24 months of age.
- More sensitive to the broader autism spectrum.
- Uses the 9 items from the original CHAT as its basis.
- Adds 14 additional items (23-item total).
- Unlike the CHAT, however, the M-CHAT does not require the screener to directly observe the child.
- Makes use of a Yes/No format questionnaire.
- Yes/No answers are converted to pass/fail responses by the screener.
- A child fails the checklist when 2 or more of 6 critical items are failed or when any three items are failed.

Modified Checklist for Autism in Toddlers (M-CHAT)

Behavioral Screening of Infants and Preschoolers

- **Modified Checklist for Autism in Toddlers (M-CHAT)**
  - The M-CHAT was used to screen 1,293 18- to 30-month-old children. 58 were referred for a diagnostic/developmental evaluation. 39 were diagnosed with an autism spectrum disorder (Robins et al., 2001).
  - Will result in false positives.
  - Data regarding false negative is not currently available, but follow-up research to obtain such is currently underway.

Modified Checklist for Autism in Toddlers

Modified Checklist for Autism in Toddlers

Please fill out the following about how your child usually does. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if your child does not do it.

1. Does your child make unusual finger movements near his/her face?  No
2. Does your child ever bring objects over to you to show?  No
3. Does your child ever seem oversensitive to noise? (e.g., plugging ears)  No
4. Does you child understand what people say?  Yes
5. Does your child walk?  No
6. If you point at a toy across the room, does your child look at it?  No
7. Does your child sometimes stare at nothing or watch with no purpose?  No
8. Does your child make unusual face expressions?  No
9. Does your child ever use his/her index finger to point, to indicate?  No
10. Does your child ever look at things you are looking at?  No
11. Does your child take an interest in other children?  Yes
12. No
13. NO
14. NO
15. NO
16. No
17. No
18. Yes
19. No
20. Yes
21. No
22. Yes
23. No

M-CHAT Scoring Instructions:

A child fails the checklist when 2 or more critical items are failed or when any three items are failed. Yes/no answers convert to pass/fail responses. Below are listed the failed responses for each item on the M-CHAT. Bold capitalized items are CRITICAL items.

Not all children who fail the checklist will meet criteria for a diagnosis on the autism spectrum. However, children who fail the checklist should be evaluated in more depth by the physician or referred for a developmental evaluation with a specialist.

**Behavioral Screening of Infants and Preschoolers**

- **Pervasive Developmental Disorders Screening Test - II (PDDST-II)**
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**Behavioral Screening of Infants and Preschoolers**

- **Pervasive Developmental Disorders Screening Test - II (PDDST-II)**
  - Has three stages
  - The PDDST-II: Stage I designed to help determine if a given child should be evaluated for an ASD.
  - Designed to be completed by parents.
  - Should take no more than 5 minutes.
  - Odd numbered items are the critical questions used for autism screening.
  - If three or more of the odd numbered items are checked as being “YES, Usually True,” then the result is considered a positive finding for possible ASD and a diagnostic evaluation indicated.

**Behavioral Screening of Infants and Preschoolers**

- **Pervasive Developmental Disorders Screening Test - II (PDDST-II)**
  - The odd numbered critical questions are ordered by age in order from highest predictive validity.
  - This means the more odd numbered items scored positive, and the more odd numbered items scored positive on the upper half of each section, the more strongly positive the screen.
  - Even numbered items significantly differentiate ASD-referred children from those with mild developmental disorders.
  - These items are also ordered by age in order from highest to lowest predictive validity.

**Behavioral Screening of Infants and Preschoolers**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Sensitivity</th>
<th>Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHAT: Stage 1</td>
<td>.35</td>
<td>.98</td>
</tr>
<tr>
<td>CHAT: Stage 2</td>
<td>.21</td>
<td>.99</td>
</tr>
<tr>
<td>M-CHAT: 2/8</td>
<td>.95</td>
<td>.99</td>
</tr>
<tr>
<td>M-CHAT: 3/23</td>
<td>.97</td>
<td>.95</td>
</tr>
<tr>
<td>PDD-II: Stage 1</td>
<td>.89</td>
<td>.84</td>
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</tbody>
</table>

**Behavioral Screening of School Age Children**

- **Autism Spectrum Screening Questionnaire (ASSQ)**

**Behavioral Screening of School Age Children**

- **Autism Spectrum Screening Questionnaire (ASSQ)**
  - Two separate sets of cutoff scores are suggested.
    - Parents, 13; Teachers, 11: = socially impaired children
      - Low risk of false negatives (especially for milder cases of ASD).
      - Not unusual for children with other disorders (e.g., disruptive behavior disorders) to obtain ASSQ scores at this level.
      - Used to suggest that a referral for an ASD diagnostic assessment, while not immediately indicated, should not be ruled out.
    - Parents, 19; Teachers, 22: = immediate ASD diagnostic referral.
      - False positive rate for parents and teachers of 10% and 9% respectively.
      - The chances are low that the student who attains this level of ASSQ cutoff scores will not have an ASD.
      - Increases the risk of false negatives.
### Autism Spectrum Screening Questionnaire

<table>
<thead>
<tr>
<th>Question</th>
<th>Positive</th>
<th>Total</th>
<th>True Positive Rate (%)</th>
<th>False Positive Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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Rate of false negatives is not available. Rate of false positives is 36.4%.

With a total possible score of 31, a cut off score of 15 “NO” responses was found to correctly identify 87.5% (7 out of 8) of the cases of autistic spectrum disorders.

### Behavioral Screening of School Age Children

- **Childhood Asperger Syndrome Test (CAST)**
  - A screening for mainstream primary grade (ages 4 through 11 years) children.
  - Has 37 items, with 31 key items contributing to the child’s total score.
  - The 6 control items assess general development.
  - With a total possible score of 31, a cut off score of 15 “NO” responses was found to correctly identify 87.5% (7 out of 8) of the cases of autistic spectrum disorders.
  - Rate of false positives is 36.4%.
  - Rate of false negatives is not available.

### Childhood Asperger Syndrome Test

- From Scott et al. (2002, p. 27)

### Australian Scale for Asperger's Syndrome (A.S.A.S.)

- Parent/Teacher rating scale
- 24 questions, 1-6 scale
- 10 behavioral characteristics, yes/no
  - If most questions are 2 to 6
  - If a majority of questions are yes
  - Then diagnostic referral is indicated
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**Australian Scale for Asperger's Syndrome (ASAS)**


**Behavioral Screening of School Age Children**

- **Social Communication Questionnaire (SCQ)**

- **Behavioral Screening of School Age Children**

  - Social Communication Questionnaire (SCQ)
    - Two forms of the SCQ: a Lifetime and a Current form.
    - **Current** ask questions about the child’s behavior in the past 3-months, and is suggested to provide data helpful in understanding a child’s “everyday living experiences and evaluating treatment and educational plans.”
    - **Lifetime** ask questions about the child’s entire developmental history and provides data useful in determining if there is need for a diagnostic assessment.
    - Consists of 40 Yes/No questions asked of the parent.
    - The first item of this questionnaire documents the child’s ability to speak and is used to determine which items will be used in calculating the total score.

- **Behavioral Screening of School Age Children**

  - An “AutoScore” protocol converts the parents’ Yes/No responses to scores of 1 or 0.
  - The mean SCQ score of children with autism was 24.2, whereas the general population mean was 5.2.
  - The threshold reflecting the need for diagnostic assessment is 15.
  - A slightly lower threshold might be appropriate if other risk factors (e.g., the child being screened is the sibling of a person with ASD) are present.

- **Behavioral Screening of School Age Children**

  - While it is not particularly effective at distinguishing among the various ASDs, it has been found to have good discriminative validity between autism and other disorders including non-autistic mild or moderate mental retardation.
  - The SCQ authors acknowledge that more data is needed to determine the frequency of false negatives (Rutter et al., 2003).
  - This SCQ is available from Western Psychological Services.
Next Week

- Read Brock et al., Chapters 5-7.
- Recommended Reading:
  - Thomas & Grimes, Chapter 94.
- Autism group project/lecture due.