ACCUMULATED EXPERIENCES OF A DUTCH AUTISM EXPERT TEAM FOR TODDLERS & PRE-SCHOOLERS

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Background

Although diagnosing a child with ASD is possible at a young age, the **diagnostic process is complex** (Steiner et al., 2012). For, the child is (1) subject to rapid behavioral developmental changes and potential regressions, and (2) very sensitive to changes in its immediate environment. Therefore, it is important to do an extensive and thorough assessment.

International guidelines (NICE, 2011) for **ASD diagnosis in young children** recommend: 1) a multidisciplinary specialist autism team, preferably consisting of a pediatrician/clinical psychiatrist, a psychologist, and a speech therapist, 2) working with experts in autism diagnostics in young children, 3) a case coordinator, 4) start assessment within 3 months after referral, 5) using different information sources (home life, nursery/playground/school, …), 6) mapping physical health and medical history, and 7) consideration of co-morbidity and differential diagnostics.

Diagnostic assessment exists of questioning parental concerns (based on child behavior in various environments), a developmental history (specifically aimed at joint attention skills, executive functioning and sensory information processing), skill observation(s), details on day-to-day functioning (home life and day care/education), a medical history and a profile of strengths and weaknesses (including cognition and language) (Dutch clinical best estimate: Blijd-Hoogewys et al., 2017).

Objectives

Sharing clinical experience in diagnosing ASD in young children (< 6 years).

Methods

Our Autism Expert Team exists of 18 professionals: 1 child psychiatrist, 1 pediatrician, 1 clinical psychologist, 4 health care psychologists, 5 (educational) psychologists, 1 speech/language therapist, 3 home treatment specialists, 1 play therapist, and 1 case coordinator.

From **April 2013 until February 2019**, we assessed **373 children** (see Table 1), following the above mentioned guidelines for autism diagnostics in young children, also using the ADOS-2, language and intelligence tests. Observations were done both at our center (structured play), at home (free play) and at day care or school.

For this poster, we assessed the **record review data** of these children.

Table 1: Descriptives research group

Year	2013	2014	2015	2016	2017	2018	2019
Boys	38	34	49	34	51	54	8
Girls	13	19	10	13	24	22	4
Total	51	53	59	47	75	76	12

Table 2: Distribution of gender over age

Age	<1	1	2	3	4	5	>6
Boys	4	8	44	76	68	33	35
Girls	0	7	19	29	26	19	5
Total	4	15	63	105	94	52	40

Results

Of the 373 children, 72% were boys and **28% girls** (see Table 2). We regularly see children from other cultures (e.g. African, Antillean, South American, Eastern European, Filipino, Indian, Pakistani and Russian).

The first assessment occurred on average 2 weeks after referral. In 53%, an ASD diagnosis was confirmed. In the youngest children, often a **DC 0-5 diagnosis** was made, which at a later age, after reassessment, was often changed into ASD. In 17% of the cases, there was no psychiatric diagnosis. These children were kept under review. **Reassessment** occurred in 34% of the children, which occurred 1-2 years later, when new concerns were raised.

Co-morbidity was often present, such as a developmental delay (45%) or language deficits (55%). Often, there were additional problems concerning sleeping, eating, potty training, motor skills and/or parent-child interaction. Children were regularly referred to clinical genetics, to look into underlying genetic causes.

Conclusions

Despite the good reliability of ASD classifications at a young age, it is important to keep track of children in their development and to evaluate them regularly. Re-assessment is strongly recommended in young children (<4 years), because the development of young children is rapid. Cognitive and language skills are still developing strongly and there is a great intertwining with the environment.

References

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