



Sur le

Number 5
Spring 2018

spectre

The Montreal Cognitive Neuroscience Autism Research Group



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"Frank" Autism



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Comic strip



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Centre intégré
universitaire de santé
et de services sociaux
du Nord-de-
l'île-de-Montréal

Québec



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Sur le spectre:

A scientific source of information on autism



Valérie Courchesne
Ph.D.

Chief editor

We are extremely fortunate to witness the growth of our editorial team, which allows us to diversify the contents of this magazine.



Official magazine of the The Montreal Cognitive Neuroscience Autism Research Group

The Montreal Cognitive Neuroscience Autism Research Group focuses on brain function, auditory and visual perception, exceptional skills and interventions in autism.

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It is with great pride that we present to you the 5th issue of Sur le spectre, produced by the Montreal Cognitive Neuroscience Autism Research Group.

This issue is again made up of articles written on a volunteer basis by researchers, clinicians and students from our group, as well as collaborators and colleagues. We are extremely fortunate to witness the growth of our editorial team, which allows us to diversify the contents of this magazine. As usual, you will find the reference for all original articles covered in this edition. Do not hesitate to consult our website, www.autismresearchgroupmontreal.ca and to like our Facebook page for updates on our group's activities.

In this edition, you will find a two-part article on autism diagnosis. We will also touch on collaborations between professionals and families, best practice guidelines for autism intervention around the world, hyperlexia, "frank" autism and lastly a toolkit on enrolment in childcare services.

Having built quite a following, we hope that you enjoy this 5th issue! If you have not yet signed up for our newsletter through our website, this will ensure that you receive every subsequent issue of Sur le spectre.

Once again, we would like to thank all those who contributed to this issue. It is thanks to you that this project has not only been sustained, but has continued to grow. Thank you also to all our research participants, who generously give their time and provide us with access to precious information. Thank you to the Associate Director of Media Relations of the Centre intégré universitaire de santé et de services sociaux du Nord-de-l'Île-de-Montréal (CIUSSS NIM), who are renewing their support with this 5th edition. Lastly, we would like to communicate our sincere gratitude to the Fondation des Petits Trésors for covering printing fees, and who have been constant supporters issue after issue.

Happy reading! 



Parental involvement and participation are considered important factors for successful implementation of many different stimulation or rehabilitation programs.

Parent-professional collaborations:

intersections of expertise

By ISABELLE COURCY, PH.D.

Families play a key role in developing the autonomy and social integration of persons with autism. Parental involvement and participation are considered important factors for successful implementation of many different stimulation or rehabilitation programs. This promotion of the parent's role in their child's programs and interventions is in fact quite recent in autism's history. Indeed, many professionals, educators, and service providers now consider parents to be partners and co-educators. Whilst these changes indicate a wider recognition of the role played by parents, their relationship to other professionals and educators still seems problematic in certain ways. As a researcher, I was drawn to the discrepancy between a professed will to provide more agency to parents, and the difficulties parents express regarding these relationships¹. Why do so many parents feel unheard, as though no one truly listens or takes them seriously? What do we know of the hurdles they face? How can we make true collaboration happen?

Challenges in the parent-professional collaboration

Parents report numerous difficulties in collaborating with the professionals and educators who work with their child. Some parents recall that their initial concerns were not taken seriously by the healthcare professionals they first consulted about their child's development. Many express regret that the professionals present during the official diagnosis announcement didn't take enough time to explain their child's condition and the different interventions they could benefit from. When taking the necessary steps to obtain help for their child, many parents feel it was left to their own devices to seek out information on available services. It was often by chance or through social media that they became aware of financial assistance they could benefit from.

Many parents confronted with important waiting times criticised having to "shout louder than the others" and

¹ Readers interested in the research projects which collected this data can consult the suggested references at the end of this article



lodge official complaints in order to gain access to services. Some reported complying with certain professionals' expectations out of fear of losing access to their services. Others made the painful decision to refuse services their work schedules made it unmanageable. Also, tensions may arise from different perceptions of children's abilities. Whilst some parents feel that some professionals minimise their child's difficulties, others find that their child's strengths and potential are not taken into account. A lack of consistency between different fields also gives parents the impression that the service providers defend their own interests over those of the child. In sum, without calling into question the goodwill of any of the involved parties, these different obstacles lead to distrust and tense interactions between parents and professionals.

Recognising different ways of knowing and intersections of expertise

That being said, parents who report satisfactory collaborations with professionals and educators tend to feel like they are at the center of the collaborative relations built around their child. Parents, especially mothers, describe feeling empowered when able to participate in decision making. In addition to providing privileged access to information, this type of collaboration promotes their abilities as parents while boosting their confidence. The collaborative relationships parents appreciate are also described as providing their child with effective educational support, as well as practical knowledge for parents to further this learning with their child.

Despite the difficulties they encounter, parents will over time develop an excellent understanding of their child's character (strengths, weaknesses, preferences and interests for example). Mothers and fathers hold knowledge that is complementary to the educators' expertise. This knowledge, acquired through daily encounters with their child and multiple quests for information and services, can also be enhanced through interactions with educators and professionals. Therefore, an important way to create a real partnership with families is to recognise parents as expert on their own child. Whilst parents have specific questions and needs, taking their knowledge into account allows interventions to be better tailored to children's peculiarities, as well as an opportunity for professionals to learn from their daily observations and experiences. This exchange of knowledge can also contribute to a feeling of self-efficacy, which improves parents' participation and the quality of parent-professional relationships. Seen this way, a successful parent-professional collaboration is one which allows for reciprocal exchange of knowledge and that recognises intersections of skills and experiences. 🌸



photo credits:
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Isabelle Courcy is a researcher with the Centre de recherche et de partage des savoirs InterActions du CIUSSS du Nord-de-l'Île-de-Montréal, and an associate professor in the Department of Sociology, at the Université du Québec à Montréal. She co-edited the book, "Autisme et TSA: quelles réalités pour les familles?" and has written numerous articles on the experiences of mothers and fathers of children with autism. Her research interests focus on support networks, health and life trajectories of people with autism, as well as the collaborative inter-professional and cross-sectorial linkages that develop around the person and their loved ones. 🌸

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Firstly, a large majority of clinicians (97%) report an experience of “frank” autism (also referred to as “hallway autism”, to imply that it was recognisable since the person entered the waiting room

“Frank” Autism

By LAURENT MOTTRON, MD, PH.D.

Do we recognise autism by virtue of having previously seen and remembered it, or rather by consciously and deliberately applying criteria one after the other? And if we do recognise it as we would a face, without a second thought, do we recognise it according to the specific criteria outlined for example in the DSM-5 (a clinician’s bible for diagnosing mental disorders)? These are the questions that Ashley de Marchena, a young researcher, attempted to address. For this purpose, 151 clinicians, each with 1 to 40 years of diagnostic experience, were asked to fill questionnaires investigating the time they needed to detect autism in a person, and the factors they reported using to make this judgement.

The results are startling. Firstly, a large majority of clinicians (97%) report an experience of “frank” autism (also referred to as “hallway autism”, to imply that it was recognisable since the person entered the waiting room; our group uses the term *prototypical* autism). Autism is therefore recognised by the clinician prior to confirmation through comprehensive diagnostic assessment in an average of 40% of people who go on to receive a diagnosis of autism. Furthermore, this recognition of autism occurs independently from the person’s level of functioning or language abilities. For example, it may occur as frequently in a non-verbal individual and a person who talks extensively. What this tells us is that the “frank” or prototypical autism identified by experts is not associated with intellectual disability (contrary to popular belief that “real” autistic people are those with an intellectual disability). Clinicians require, on average, less than 10 minutes to form this impression. Lastly, this capacity to recognise autism so rapidly is determined not by profession (psychologist or physician), but by the number of autistic people the clinician has previously evaluated.

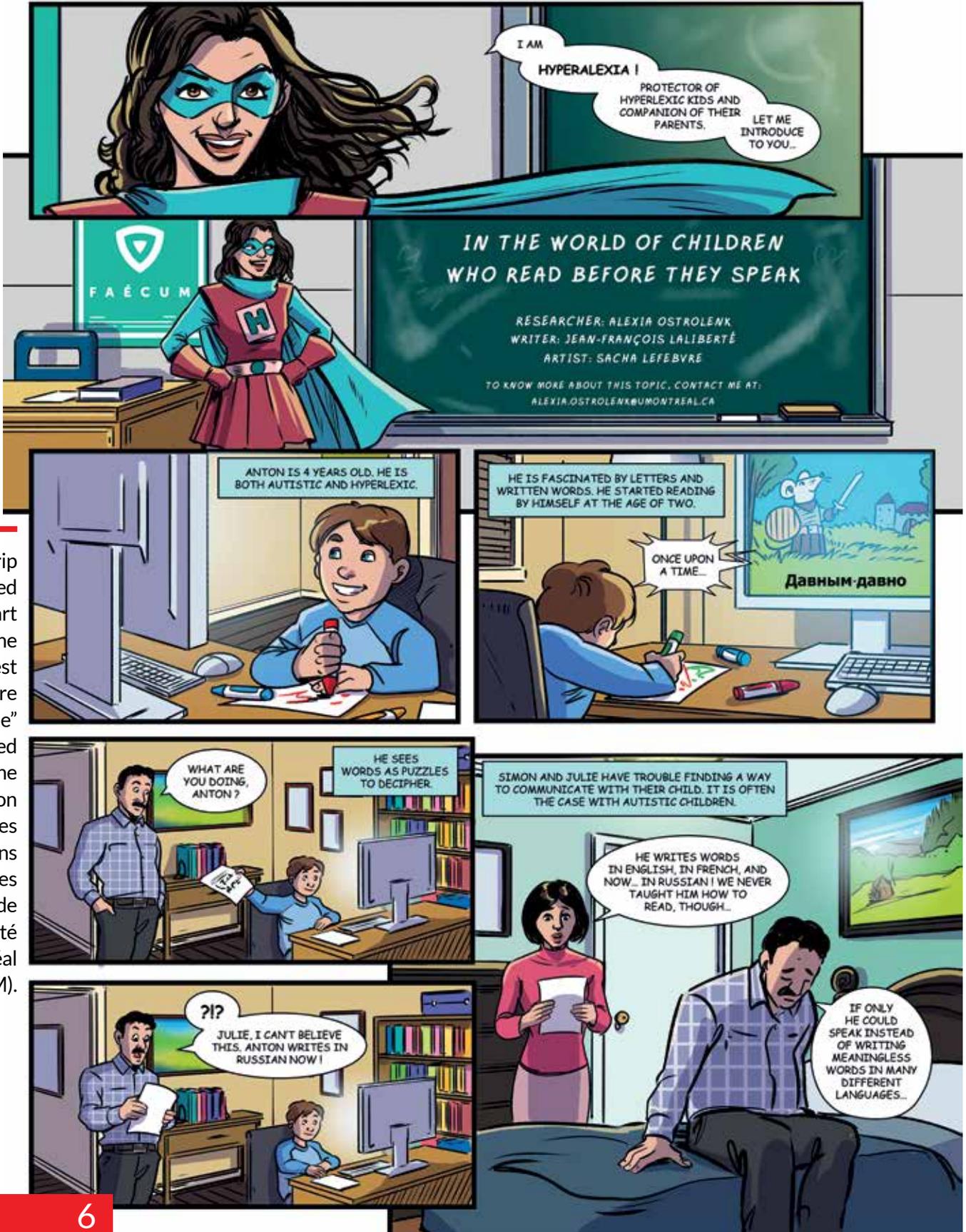
One of the findings of this study is that “frank” autism is recognised in part based on criteria which differ from those outlined in diagnostic manuals such as the DSM-5. An apparent lack of social reciprocity in eye gaze or facial expressions, both of which are part of DSM-5 diagnostic criteria, indeed play a large role in the recognition of “frank” autism, but clinicians also rely on atypical gait, intonation and posture, which are not mentioned in DSM-5. Furthermore, DSM-5 criteria largely emphasise socio-communicative signs in

diagnosing autism, whilst this study reported that repetitive behaviours were what first came to mind in terms of traits facilitating a recognition of “frank” autism. Ultimately, this recognition does not occur *differentially*, as is the case when one makes a differential diagnosis by distinguishing one condition from another, which might also explain the same symptoms. Clinicians therefore recognise autism as one might recognise a face: when I recognise someone, there is no need for elaborate reasoning to eliminate other possible identities, except in cases where a face might be blurry or partially hidden.

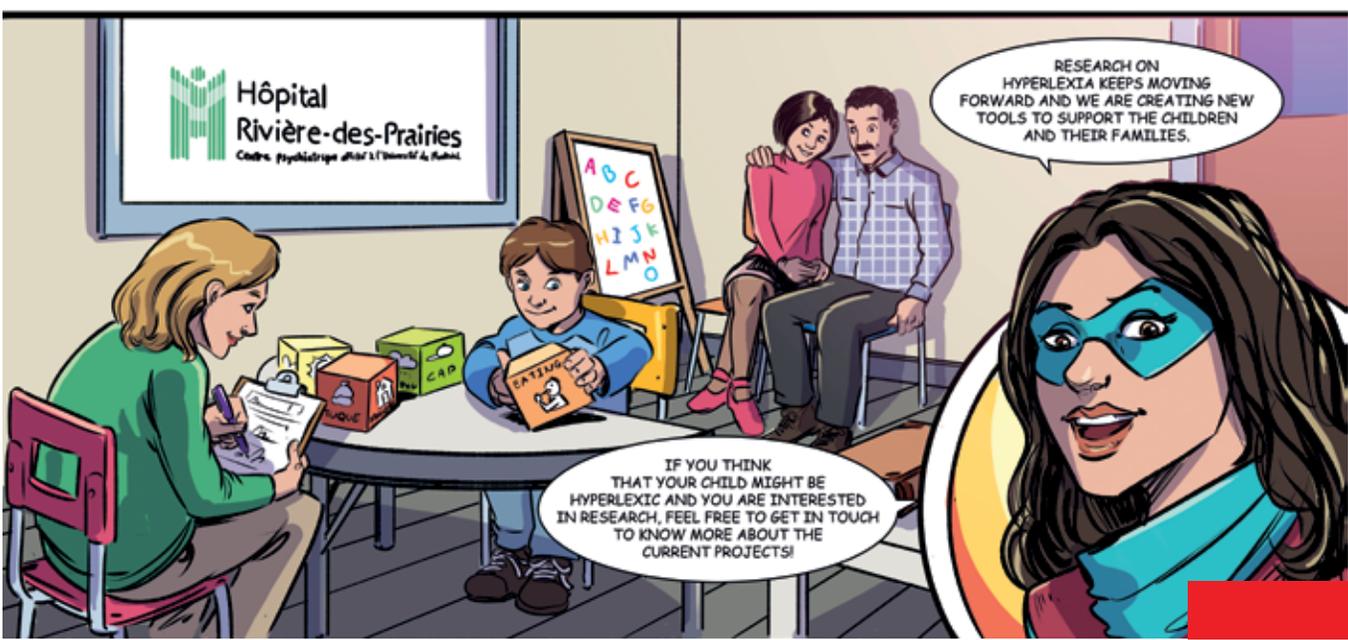
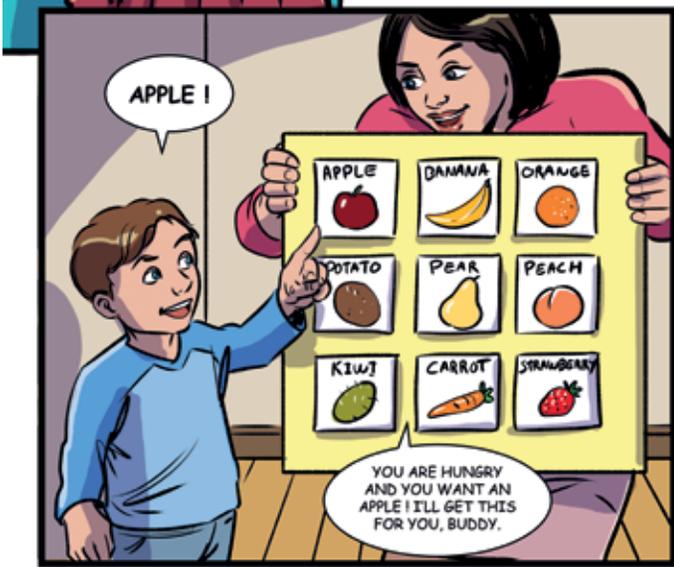
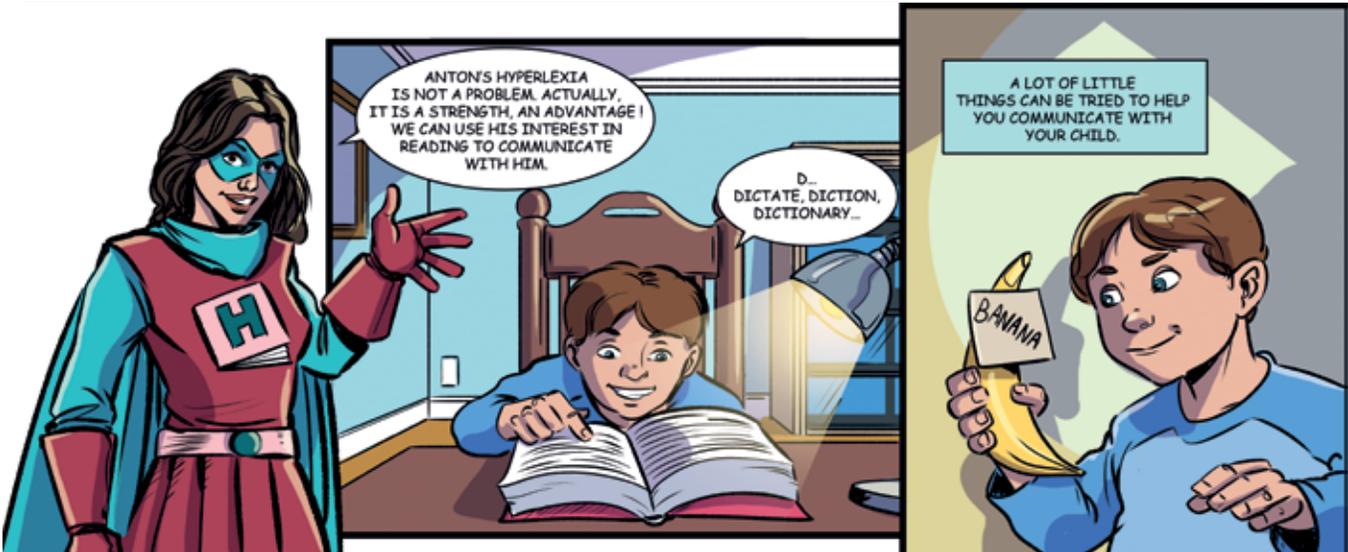
These results explain findings from another study, which demonstrated that consciously applying diagnostic criteria improved reliability of diagnosis in inexperienced clinicians, but *compromised* it in experts! What this suggests is that exposure to numerous cases of autism is essential for building good diagnostic skills, and that scientists would potentially have a lot to gain from studying “frank” autism traits, who appear more typical of the condition than those presently being studied around the world. This could help to determine with more certainty whether people in the grey area of autism (i.e. not belonging to the “frank” autism group) are indeed autistic, or if the resemblance is merely superficial. 

Lastly, this capacity to recognise autism so rapidly is determined not by profession, but by the number of autistic people the clinician has previously evaluated

Reference of the original article: de Marchena, A., & Miller, J. (2017). “Frank” presentations as a novel research construct and element of diagnostic decision-making in autism spectrum disorder. *Autism Research*, 10(4), 653-662.



Comic strip realized as part of the contest "L'illustre recherche" organized by the Fédération des associations étudiantes du campus de l'Université de Montréal (FAÉCUM).





Consequently, the diagnostic team, specifically the psychiatrist, will attempt to assess not only autistic symptoms, but other symptoms which can be mistaken for or linked to autism.



Autism diagnosis 101:

process and psychiatric assessment

By **BAUDOIN FORGEOT D'ARC, MD, PHD** and
by **PASCALE GRÉGOIRE, MD, FRCP (C)**

Each year, over 300 families visit the ASD assessment clinic at Rivière-des-Prairies Mental Health Hospital. This article is the first of a series of two articles on autism diagnosis, and will examine the main issues faced by psychiatrists during autism diagnosis assessments. Whilst limited in scope, in this article we will share a few thoughts related to our clinical experience as psychiatrists working with families at Rivière-des-Prairies Mental Health Hospital (RDPMHH).

1. Background

At RDPMHH, ASD assessment referrals are made by physicians from other clinics and institutions. The assessment is carried out by a multidisciplinary team made up of a psychiatrist and other professionals such as a psychologist, a psychoeducator, a speech-language pathologist and an occupational therapist.

2. Why diagnose?

A diagnosis is first and foremost an answer to a question (quite often many). It most usually stems from a need to explain a problem that has been observed. Provision of services in Quebec is organised in such a way that we are prompted to answer a yes or no question: "Autistic or not autistic?". Indeed, most intervention programs and academic support services depend solely on this

diagnosis (e.g. ASD classrooms, CDRITED etc...). Whilst it is understandable that these specialised services are reserved for those having obtained a diagnosis, a person's needs are often determined by many other aspects of their situation. Consequently, the diagnostic team, specifically the psychiatrist, will attempt to assess not only autistic symptoms, but other symptoms which can be mistaken for or linked to autism (ADHD, anxiety, depression, OCD, personality disorders etc...). One of the challenges of assessment is therefore to work with the family to develop a general understanding of the person, their needs, their strengths, their environment, all while moving toward potential solutions. For example, a person's distress or dysfunction can be attributed to other problems, even if signs permitting an autism diagnosis are present. In short, it may not always be possible to answer this yes or no question accurately at any given moment, and this question is also not always the best one to ask!

3. The procedure

The assessment relies on information gathered from the person's environment (often family and school) and direct observation by clinicians. These steps may use standardised tools, that is, procedures which guide professionals through the assessment and interpretation



of results. In Quebec (and many other places around the world), the most commonly used ones are the Autism Diagnostic and Observation Schedule (ADOS-2) and the Autism Diagnostic Interview (ADI-R). The ADOS-2 is a method involving observation of the person during interactions with the evaluator, whilst the ADI-R is an interview conducted with parents. The psychiatric assessment attempts to consider the situation as a whole, including other diagnoses and needs. Other assessments may for example complement this procedure, such as language, intelligence or sensorimotor development assessments. A diagnosis is then made based on all the collected information.

4. Pitfalls

The yes or no question

The creation of specialised services for autistic people has on the whole been extremely beneficial, but has also created new hurdles since access to these services is usually dependant on a diagnosis of autism. For example, take an adolescent presenting with serious conduct problems, who received a diagnosis of autism as a child but no longer presents clear signs of ASD. Forcing a decision on his ASD status would be unwise, whilst intervention and orientation needs remain overwhelmingly clear. In certain cases, taking a step back or even observing the effects of an intervention which addresses prioritised needs (for example, anxiety) can help to make a more accurate diagnosis at a later date. It is therefore necessary to reconsider the necessity of an ASD diagnosis within intervention and other psychiatric diagnoses in order to allow more flexible access to and provision of services. This would allow us to first and foremost address the person's needs, independently of psychiatric diagnoses.

The downfalls of standardised assessments

Whilst standardised tools help assessors to be more systematic, and ensure that autism diagnoses are conducted similarly everywhere in the world, they contribute to an assessment setting where a complex clinical case will be summarised to a yes or no answer. It can also be reassuring to rely on these widely-used tools to deliver a difficult conclusion, or to present it as a goal. However, we must keep in mind that these tools have limits, and that it is crucial to contextualise the scores obtained from these scales with other information and observations collected during the assessment, in order to make the best possible use of them.

5. Summary

In sum, diagnosis can sometimes help us to better understand what is happening, to officially name the difficulties experienced by the person and their family, and to guide intervention. It can help us to take a step back, address feelings of guilt, and therefore may come as a relief. On the other hand, the word "autism" is sometimes linked to strong assumptions, which may or may not reflect the diversity of situations observed at the individual level. Diagnosis is a puzzle. It does not determine who a person is or what the future holds for them. With this in mind, disclosing a diagnosis is a crucial moment and a delicate task. Our team is presently developing tools to improve this procedure, and we will be addressing this in the second article of this series. 🌸

Whilst standardised tools help assessors to be more systematic, and ensure that autism diagnoses are conducted similarly everywhere in the world, they contribute to an assessment setting where a complex clinical case will be summarised to a yes or no answer.

Autism diagnosis 101:

a guide to communicating with autistic people and their families

BAUDOIN FORGEOT-D'ARC, GHITZA THERMIDOR, VÉRONIQUE LANGLOIS and LINE LAPORTE

These texts are further contextualised using short stories from autistic children, teenagers and adults.



An assessment clinic with diverse needs

Each year, over 300 families visit the ASD assessment clinic at Rivière-des-Prairies Hospital. This is our second article on autism diagnosis, and addresses the practices surrounding the disclosure of an autism diagnosis. Indeed, when a diagnosis of autism is confirmed in children and adolescents, the assessment team not only provides personalised guidance on intervention services (support, stimulation, rehabilitation, psychiatry etc...) but helps those involved to better understand their situation, and come up with ways it can be improved.

Parents most frequently report a need for information that is both general and personalised, as well as support services in the form of guidance and counselling. It is also vital to provide information to autistic children and adolescents. For this reason, special attention is paid to communicating clear and valid information to the person being assessed, their loved ones and their intervention team. Due to the high stakes at play during this brief interaction, our team has elected to develop a guide book which will provide information, support and facilitate communication during these appointments.

A Communication Tool

"Rencontre avec l'autisme : pour comprendre et agir" is the guide book we have developed, based on our current understanding of autism, best practice guidelines and our own clinical experience with disclosing the diagnosis to autistic people and their families. This collaborative work¹ is illustrated by Laura Charrette (graphic designer, recipient of two student awards from the 2018 Grafika contest- see ref.² for more information). The guide consists of brief texts which explain autism, provide guidance on interpreting an autism diagnosis, recommend interventions, and outline the service network in Quebec. These texts are further contextualised using short stories from autistic children, teenagers and adults. Vignettes help to make commonly available information clearer and more accessible, by illustrating how situations may play out in everyday life. In addition, worksheet-style exercises allow families to personalise the guide book to better fit their experiences. These exercises also aim to encourage dialogue between service users and professionals.

Constantly Improving Clinical Practice

A "working version" of this tool was recently incorporated into our clinical practice, to allow clinicians to familiarise themselves with its contents and service users to provide feedback prior to publishing a final version. In this way, we are measuring the tool's *acceptability* in the context of our assessment clinic.

What could be the *impact* of this new tool on our practice? We are presently evaluating the extent to which it may improve the experiences of service users with respect to care provided, and thus their overall satisfaction. By facilitating access to a relevant body of information, we hope that this guide book will improve the understanding of autism in health-service users, and represent a significant first step in their subsequent journey. 🌻

References:

¹ Forgeot d'Arc B, Thermidor G, Chrétien M, Lajeunesse S, Laporte L. Rencontre avec l'autisme: pour comprendre et agir. Illustrations: Charrette L. 2018, 94 pages. ISBN: 978-2-550-80235-8.

² www.lauracharette.com

Note: Encountering Autism: towards understanding and action" is not yet available to the public nor professionals. The purpose of this article is to describe a process by which diagnosis disclosure practices may be improved, and not to advocate a particular approach. Our procedure is still under development, and results will be communicated shortly. Follow "Sur le spectre" for updates! For any queries concerning validation, contact b.forgeot@gmail.com.



Best Practice Recommendations in Autism

By JÉRÔME LICHTLÉ, psychologist

In order to guide professionals and families towards better autism care, healthcare organisations in several countries provide Best Practice Recommendations (BPRs). This article aims to summarize five national BPRs:

- The Haute Autorité de Santé (HAS, France, 2012)
- The National Institute for Health and Care Excellence (NICE, United Kingdom, 2013)
- The Centre Fédéral d'Expertise des Soins de Santé (KCE, Belgium, 2014)
- Healthcare Improvement Scotland (SIGN, Scotland, 2016)
- New Zealand Autism Spectrum Disorder Guideline (New Zealand, 2016)

Note: The scope of this article is restricted to children and adolescents, and non-pharmacological interventions.

The following list seeks to first address interventions and approaches that will not be addressed in this article. Whilst not necessarily harmful, these approaches cannot be recommended given the lack of scientific proof of their efficacy:

- Psychoanalytic and psychodynamic approaches (France, Belgium, New Zealand)

- Institutional psychotherapy (France, Belgium)
- Son Rise program (France)
- The 3i method (France)
- Feuerstein method (France)
- Padovan method, of neurofunctional reorganisation (France)
- Floortime or Greenspan method, when used exclusively (France)
- Doman-Delacato method (France)
- Neurofeedback and auditory integration therapy to address speech and language problems (United Kingdom)
- Packing (Belgium)
- Facilitated communication (Scotland, France, Belgium, New Zealand)

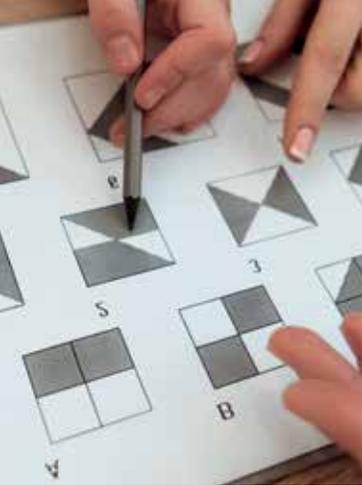
The BRPs make the following collective recommendations:

1. Early Interventio

Example:

- France: "Personalised programs based on early, comprehensive and coordinated intervention models, implemented before the age of 4" (grade B)

It is important that children and their families should have access to early intervention wherever possible.



Note: with respects to strategies aiming to decrease the frequency of problem behaviours, front line interventions should first prioritise the acquisition of new skills. Indeed, proactive learning will often indirectly reduce the frequency and intensity of problem behaviours. (HAS, France).

- United Kingdom: "It is important that children and their families should have access to early intervention wherever possible"

2. Involve parents and/or favour programs with a parental training component

Example:

- Scotland: "Parent-mediated intervention programmes should be considered for children and young people of all ages who are affected by ASD, as they may help families interact with their child, promote development and increase parental satisfaction, empowerment and mental health" (recommendations based on clinical experience of the Guideline Development Group)
- United Kingdom: "Strategies should aim to increase the parents' understanding of and sensitivity and responsiveness to the child or young person's patterns of communication and interaction."
- New Zealand: Parents should be provided with "guidance on mastering specific teaching strategies that enable them to help their child acquire new skills and behaviours, information on understanding how ASD influences their child's learning and behavior, and help in coping with emotional stress"

3. Focus on child's strengths and interests

Example:

- France: "Initial use of child/adolescent's specific interests" (to promote cognitive functioning)
- United Kingdom: "If children and young people express interest, offer a collaborative approach to treatment and care that takes their preferences into account."

4. Provide alternative communication tools

Examples:

- Scotland: "Interventions to support communicative understanding and expression in individuals with ASD should be considered"
- United Kingdom: "Strategies should include techniques to expand the child or young person's communication"
- New Zealand: "Visual supports and technology should be available to support expressive and receptive

communication and organisation according to the child or young person's individual needs (Grade B)"

5. Promote social inclusion and access to education, culture and recreation

Example:

- New Zealand: "All children and adults should have access to leisure facilities and meaningful activities tailored to their needs and interests (...)" ("Living in the Community", Grade B)
- United Kingdom: "supporting access to leisure and enjoyable activities; and support access to educational services"

6. Target the improvement of joint attention skills

Example:

- Belgium: "Core approaches to sociocommunicative difficulties ideally involve an interactive play-based psychosocial intervention (...) in order to improve the child's joint attention, engagement and reciprocity"
- Scotland: "statistically significant benefit from parent-child interaction for joint attention"

7. Consider behaviour analysis-based approaches

Example:

- United Kingdom: "If no coexisting mental health or behavioural problem, physical disorder or environmental problem has been identified as triggering or maintaining the behaviour that challenges, offer the child or young person a psychosocial intervention (informed by a functional assessment of behaviour) as a first-line treatment for behaviour that challenges."
- Belgium: "Cognitive behavioural interventions are recommended to manage anxiety disorders in children with the cognitive and verbal development required to participate"
- New Zealand: "Educational interventions should incorporate principles of positive behaviour support, particularly a focus on understanding the function of the child or young person's behaviour" (Grade A). 

For further information, the full text version of this article can be accessed online (in French) by visiting: <https://blog.francetvinfo.fr/dans-vos-tetes/2017/12/12/autisme-queles-sont-les-interventions-qui-marchent.html>



TOOLBOX FOR PARENTS

By MARTINE DANSEREAU and GHITZA THERMIDOR



Integration into childcare services

- My child has just obtained an autism spectrum disorder diagnosis. I would like to enroll him in a childcare facility, are any resources available to help my child within this structure?

Your child has just obtained an autism spectrum disorder diagnosis, and you would like to enroll him in childcare facility. Before enrolling your child, it is important to be aware of the different types of childcare services available. Some are entirely or partially subsidised, and others are entirely private. Only subsidised childcare services have access to an allowance to help integrate a child with a disability into a childcare centre.

- Which childcare services are subsidised?

Early Childhood Centres
(Centre de la petite enfance, CPE)

Subsidised private daycares
Subsidised home daycares

- What is the allowance to help integrate a disabled child?

The ministère de la Famille is responsible for subsidised childcare services. These services are supported through special funding to integrate children with disabilities into childcare services, as per its integration policy. This funding is divided into two components:

- The first component is dedicated to administrative costs, such as costs related to managing the child's file as well as those associated to material resources (Ministère de la Famille, 2017)
- The second component is dedicated to putting in place the means to ensure that integration targets are met, such as decreasing the number of children per educator, hiring staff or assistants, training or replacing staff receiving training etc.

Childcare providers who work with a child with a disability are **responsible** for promoting the child's integration and for using these funds solely for the above purposes.

- Which documents are needed to obtain this allowance?

In addition to a professional report attesting to your child's disability, your child's application to childcare services must also include recommendations from at least one professional on measures to put in place in order to promote your child's integration. These recommendations should more specifically clarify the material and human resources necessary to support your child. A form currently exists that professionals may fill out. Finally, a childcare integration plan is mandatory for this process.

- Which professionals can fill out this form?

Physicians
Occupational Therapists
Physical therapists
Optometrists
Audiologists
Speech therapists
Psychologists
Psychoeducators
(Ministère de la famille, 2017)

- What processing times can I expect?

"Childcare service providers are eligible to receive the allowance starting from the date where the parent's file contains all required documents" (Ministère de la famille, 2017)

- My child displays daily problem behaviours, are childcare services within their right in turning away my child?

"Although childcare and educational services may select their clientele (depending on their organisational structure and resources), the Quebec Charter of Human Rights and Freedoms prohibits any discrimination on the basis of disability. Therefore, it is expected that educational settings will undertake reasonable efforts to integrate a child with a disability when parents require a place." (Ministère de la famille, 2017)

- What if I have further questions of a complaint to lodge?

You must contact the Minister of Families. 



Childcare providers who work with a child with a disability are responsible for promoting the child's integration and for using these funds solely for the above purposes.

Bibliography:
https://www.mfa.gouv.qc.ca/fr/publication/Documents/SF_recherche_service_garde.pdf
https://www.mfa.gouv.qc.ca/fr/publication/Documents/Garderies-Regles_budgetaires-17-18.pdf
<https://www.mfa.gouv.qc.ca/fr/publication/Documents/Directive-AIEH.pdf>

Ongoing research project!: This research project is underway at Rivière-des-Prairies Hospital's Cognitive Neuroscience Autism Research Laboratory.

Seeking participants

Questionnaire on strengths and interests in young children



For further information or to participate, please contact Vanessa Larose, study coordinator (under the supervision of Dr. Claudine Jacques).

Vanessa Larose, B. Sc.
Doctoral candidate in Psychology, UQO

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514-757-5242

Aim: to document the strengths and interests of autistic and typical children aged between 2 and 6.

Study requirements: completion of a **telephone-administered questionnaire** on strengths and interests.

Time: 20-30 min

Eligible participants should:

- Be a parent of an autistic or typical child aged between 2 and 6.
- Have adequate knowledge of French.

Advantages to participation: Random draw of 8 Walmart gift cards (\$25 value).

