



Early Intervention

What is Early Intervention?

Mandated by the federal Individuals with Disabilities Education Act (Part C) and, in California, by the California Early Intervention Services Act, early intervention services are a coordinated set of services designed to help eligible children close any developmental gaps. Services include, but are not limited to, speech and language therapy, occupational therapy, physical therapy, infant stimulation, nursing services, etc.

Effective January 1, 2015, eligible infants and toddlers include those who, through documented evaluation and assessment, meet one of the following criteria:

1. have a developmental delay in either cognitive, communication, social/emotional, adaptive, or physical and motor development, including vision and hearing; or
2. have established risk conditions of known origin, with a high probability of resulting in delayed development; or
3. are at high risk of having a substantial developmental disability due to a combination of risk factors.

Your insurance carrier and/or the regional center, or a combination of both, pay for early intervention services as a means to help eligible infants and toddlers develop to their full potential. (*Title 17, California Code of Regulations, §52022; California Government Code §95014; Welfare and Institutions Code §4642*)

The initial evaluation and assessment for eligibility, and the development of the Individualized Family Service Plan (IFSP) for those eligible, must be completed within 45 days of the date that the regional center receives the referral. (*Title 17, §52086*)



Early Intervention Transition

The early childhood transition is a formal process beginning at least 6 months prior to the toddler's 3rd birthday, transitioning him/her from early start (Part C) to school programs (Part B). Federal and state law dictate that the transition process must conclude at

age 3, regardless of the child's and family's needs at that time. While Part C of the Individuals With Disabilities Education Act (IDEA) mandates a family-centered approach, Part B mandates a child-centered approach focusing on the child's educational needs.

Parents, however, remain an integral part of the team and it is important for parents to know the responsibilities of all the agencies that will be involved in their children's lives, as the services will look different and be provided in a different manner.

At 30 months...

⊗ The service coordinator must notify the parent that their toddler may be eligible for special education and related services and that transition planning will occur in the next 3-6 months.

⊗ The service coordinator must notify the local school district that there will be an IFSP meeting requiring their attendance when the toddler is between 30-33 months (as early as 30 months at the discretion of the entire team).

⊗ Within 30 days after the service coordinator notifies the parent and school district, the team must agree on the date for the IFSP for the purpose of discussing the necessary transition steps.

Title 17, §52112(b)

Between 30-33 months...

⊗ The transition meeting occurs when the toddler is between 30-33 months, and it must include the following:

⊗ Discussion and information to the parents on (1) the special education eligibility criteria; (2) community resources for toddlers who may not qualify for special

education services at age 3; and (3) steps to prepare the toddler for changes in service delivery and steps to help the toddler adjust to, and function, in a new setting.

⊗ The team will identify what assessments they will conduct to determine

service related needs after age 3 (assessments must be done in all areas of suspected disability); and

⊗ A projected date for a final review of the IFSP .

Title 17, §52112(c-d)

Between 33-35 months...

- ☼ Qualified personnel will meet with your toddler over the course of several days to conduct assessments in all areas of suspected disability, which may include, but not limited to:
- ☼ Health
- ☼ Vision & Hearing
- ☼ Speech & Language
- ☼ Occupational Therapy
- ☼ Physical Therapy
- ☼ Social-Emotional
- ☼ Adaptive Behavior
- ☼ Psycho-Educational
- ☼ Auditory Processing
- ☼ Assistive Technology

At 35-36 months...

For special education

- ☼ Convene for an IEP meeting to discuss:
- ☼ Results of the assessments (you will receive copies)
- ☼ Determination of special education eligibility at age 3 and the development of the Individualized Education Plan (IEP)
- ☼ Community resources for those who are not eligible for special education at age 3

For regional center

- ☼ Regional Center specialists will decide eligibility for services after age 3 by reviewing the following information:
 - ☼ Toddler's history
 - ☼ Progress made in Early Start
 - ☼ Current level of development
- Lanterman eligibility (for over age 3) is different and more strict than early start eligibility criteria. Many children who received early start do not qualify for Lanterman services.



Assessment timelines

1. At the transition meeting, or no more than 15 days thereafter, you will receive a proposed assessment plan.
2. You have 15 days to sign the assessment plan and return it.
3. The school personnel has 60 days to conduct the assessment

California Education Code 56321 & 56344

Tips:

- ☼ Try to get a copy of the special education assessments in advance of the meeting so that you have adequate time to review and note any questions.
- ☼ Familiarize yourself with the school district's legal responsibilities in educating your child, regional center's eligibility criteria at age 3 and your appeal rights!
- ☼ Don't be afraid to ask questions! Understand before you sign!



At 36 months...

One of three things will happen...

1. Your toddler is found eligible for continuing regional center services and also for special education services through the school;
2. Your toddler is found not eligible for continuing regional center services, but is eligible for special education services through the school; or
3. Through early start services, your child has closed any developmental gaps and is not eligible for regional center or special education.

Important Notes

- ⊗ Each agency or person who has a direct role in the provision of early intervention services is responsible for making a good faith effort to assist each child in achieving the outcomes in the their IFSP.
- ⊗ However, no agency or person shall be held accountable if an eligible child does not achieve the growth projected in the child's IFSP.
- ⊗ Not meeting IFSP goals does not, in and of itself, justify continued regional center services or special education eligibility, although it does play a factor.

Remember....

- ⊗ Prepare for each meeting as best you can. Review your child's most recent progress reports and see how far they have come with the interventions provided. This will give you a good idea of what services should continue (provided by the school district) or what services can be discontinued.
- ⊗ You can bring a friend with you to the meetings to help take notes or keep you focused.
- ⊗ Talk with other parents going through this process and learn from their experiences.
- ⊗ Maintain open lines of communication. Make sure you share your input, ask questions, and also be receptive to the recommendations of the specialists.



The State Council on Developmental Disabilities (SCDD) is established by state and federal law as an independent state agency to ensure that people with developmental disabilities and their families receive the services and supports they need.

Consumers know best what supports and services they need to live independently and to actively participate in their communities. Through advocacy, capacity building and systemic change, SCDD works to achieve a consumer and family-based system of individualized services, supports, and other assistance. The Central Coast Office is one of 12 regional offices in California.

Central Coast Office serves the following counties: Santa Clara, San Benito, Santa Cruz, Monterey, San Luis Obispo, Santa Barbara, and Ventura

Establishing Positive Sleep Patterns FOR CHILDREN ON THE AUTISM SPECTRUM

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MOST PARENTS HAVE HAD SOME EXPERIENCE WITH A CHILD WHO HAS DIFFICULTY FALLING ASLEEP, WAKES UP FREQUENTLY DURING THE NIGHT, AND/OR ONLY SLEEPS A FEW HOURS EACH NIGHT.

Temporary sleep difficulties are an “expected” phase of child development. But ongoing and persistent sleep disturbances can have an adverse effect on the child, parents and other household members. Children on the autism spectrum (ASD) appear to experience these sleep disturbances more frequently and intensely than typically developing children. It is extremely common for children with ASD to have difficulty getting to sleep, sleeping for a few hours at a time, and/or staying asleep without frequently waking throughout the night. These poor sleep habits are easily created and can be extremely difficult to change.



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Models may not have autism.





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A COMMON SLEEP-RELATED ISSUE IS A PARENT SLEEPING WITH THE CHILD WITH ASD.



IF THE CHILD IS UPSET AND OBVIOUSLY NOT SLEEPING, WAIT A FEW MINUTES AND THEN GO BACK INTO THE CHILD'S ROOM TO CHECK ON HIM/HER.

When establishing a plan to reinforce a positive sleep pattern, any underlying medical problems affecting sleep should be assessed. Consider checking for food and/or environmental allergies or intolerances, gastrointestinal disturbances, and seizures. Also sleep disturbances can be a side effect of medications. All of these are more common in people with ASD.

Sleep disorders affecting the general population should also be ruled out for your child with ASD. Sleep apnea is a disorder that can affect anyone at any age; pauses in breathing occur when the airway becomes obstructed during sleep. Common causes are enlarged tonsils or adenoids; upper respiratory illnesses and/or allergies can also contribute to the development of sleep apnea. Other symptoms of sleep apnea in children include: snoring, mouth breathing, restless sleep, sweating, night wakings, and/or frequent coughing or choking while asleep.

Other sleep disorders to assess in a child, if appropriate, include sleep terrors and confusional arousals, disorders of "partial arousal" that lead to unusual behaviors during sleep. Children with sensory processing difficulties have more problems falling asleep and night waking. An assessment and consultation with an occupational therapist trained in sensory integration may be important to assess relaxation and arousal difficulties, and to help design strategies that address these issues.

After possible medical problems have been addressed, other factors contributing to sleep problems to consider are: environmental variables, bedtime routines and sleep training methods.

ENVIRONMENTAL VARIABLES

After examining your child's sleep environment more closely, some adaptations and modifications may be needed to help your child to relax at bedtime.

1. **IS YOUR CHILD TOO HOT OR TOO COLD?** Experiment with the temperature of the room, bedding and sleep clothes to decide what combination is best for your child. Remember that your child's sense of temperature may be different than yours. Recall what temperature your child seems to prefer and/or seek during the day, and consider this when making decisions.
2. **ARE TACTILE SENSITIVITIES AFFECTING YOUR CHILD'S ABILITY TO SLEEP?** Certain textures can relax or arouse

your child. Examine bedding and pajama textures. Your child may prefer his/her feet covered or uncovered with footed pajamas, socks or even the covers themselves. Tight or loose clothing with or without elastic or seams can be an issue for some children. Also bedding should provide the optimum level of pressure, as this too can affect individuals with ASDs.

3. **ARE NOISES AFFECTING YOUR CHILD?** At night, when trying to relax and fall asleep, the noises your child hears may be impossible to filter out. Water running or an animal scratching may not affect you or other household members, but can be disrupting for a child with an ASD. Sometimes a fan, air filter, TV or soft music in the child's room can help mask other noises and provide a consistent sound that is comforting and/or soothing.
4. **ARE VISUAL STIMULI CAUSING PROBLEMS AT BEDTIME?** Is your child afraid of the dark? Some children with ASDs may prefer dark places during the day but could be afraid to sleep in a big room, in a bed, at night in the dark. Streetlights, the moon, or car lights shining in the room at intermittent intervals may also affect your child's sleep. Providing a room that is consistently light or dark may be very important, depending on your child's needs.

SLEEP TRAINING

The hardest piece in establishing positive sleep patterns is teaching your child to sleep through the night. You may have read or heard about various versions of sleep training methods. We recommend placing your child in his bed or crib, and leaving the room without long, drawn-out words or further attempts at touching the child in any way.

If the child is upset and obviously not sleeping, wait a few minutes and then go back into the child's room to check on him/her. Go back into the child's room (not more than a minute, preferably less) and briefly touch, rub or give a "high five," "thumbs up" or hug. Gently but firmly say, "It's okay, it's bedtime, you are okay" and then leave the room until it is time for the next check or until the child falls asleep.

Using this technique consistently is generally harder on the parent than it is on the child. It may take a couple of hours the first few nights. It is also very likely the child's behavior will get worse for

a few days or more before it improves. This is the child testing the change and trying to bring the old routine back. For some children who are older and not genuinely tired at a reasonable bedtime, a routine of staying in the bed or in the room quietly may be appropriate. Sleep training methods can still be applied in these situations. Also a gate or other barrier may be needed at the bedroom door to remind the child it's bedtime and the expectation is to stay in your room.

Another common sleep-related issue is a parent sleeping with the child with ASD. This habit may understandably get started when poor sleeping patterns affect not only the child but the parents and the rest of the family as well. If the child is in the habit of sleeping with a parent and/or in the parent's bed, the same steps described above should be considered with additional support needed during the examination of the environment and bedtime ritual/routine. For example, a pillow or other item(s) from the parent(s) may help make the environment more comforting to the child as the parent(s) transitions from sleeping with the child. Desensitization to a new room or bed can be added as part of a daily routine for a few days or weeks before also being done as part of the bedtime routine.

If your child is older and never consistently slept through the night, you may be sleep deprived yourself. Ask for help from your doctor, a psychologist, or social worker, or from a case manager if you have applied for Medicaid Waivers. It may not be easy to find a knowledgeable professional but you might start by asking other parents who might know a professional. Also, if your child's sleeping habits regress, you may need to consult with knowledgeable professionals. Sometimes if other medical problems are ruled out, a temporary trial of medication taken under a doctor's care can assist in turning around poor sleep patterns.

Several doctors in the field of autism spectrum disorders have done preliminary research on the short-term use of the over-the-counter supplement melatonin. Melatonin can help stabilize and promote normal sleep for some children by helping them fall asleep more quickly. The few studies currently available do caution, however, that melatonin sometimes stops working and does not usually help those who frequently wake up during the night. In addition, the long-term effect of taking melatonin has not been established.

The best advice is to avoid creating sleep routines and habits that will have to be broken later. Checking for medical issues and environmental variables, and then planning and consistently following a bedtime routine and a sleep training method can improve the quality of life for the whole family. It can take time to establish positive sleeping patterns, particularly if trying to change a long-standing problem. Families frequently have to make sleeping issues a priority until positive sleeping patterns are established, but it is a priority that is well worth the effort.

BEDTIME ROUTINES

Bedtime routines are very important for most children in establishing positive sleep patterns, but are extremely critical for children with an ASD.

1. **YOUR CHILD WILL BENEFIT FROM A SET BEDTIME.** Pick a time for bed that is reasonable for your child and which you can consistently provide.
2. **CHILDREN WITH ASD NEED TO KNOW WHAT IS GOING TO HAPPEN NEXT.** Establish a bedtime routine that can provide predictability and a comforting, familiar pattern. For further understanding and structure, a visual bedtime schedule can help. The visual schedule can provide reminders and consistency for the whole family.
3. **A GOOD BEDTIME ROUTINE WILL HELP TEACH A CHILD TO CALM DOWN, RELAX AND GET READY TO SLEEP.** For example, if bathing is stimulating or stressful for your child, it may be best to bathe at a completely different time of the day. Likewise, there may be sensory integration activities that are relaxing to your child during the day that you can also use as part of the bedtime routine.
4. **A BEDTIME ROUTINE SHOULD BE THE SAME EVERYDAY AND SHOULD INCLUDE ACTIVITIES THAT ARE PLEASANT AND RELAXING AS WELL AS SPECIAL AND INDIVIDUALIZED TO FIT YOUR CHILD'S NEEDS AND INTERESTS.** A bedtime routine should consist of 4 to 6 steps that do not take more time than is reasonable on a nightly basis.
5. **SOME ACTIVITIES TO CONSIDER AS PART OF A BEDTIME ROUTINE OR RITUAL** include looking at the same book or story each night, saying good night to favorite objects, toileting, bathing, getting pajamas on, brushing teeth, having a glass of water, singing a favorite song or prayer, listening to calming music that the child enjoys, hugging and kissing family members and/or engaging in a calming sensory integration activity.
6. **ON DAYS WHEN YOU ARE AWAY FROM HOME AND/OR GET HOME LATE, IT IS STILL IMPORTANT TO FOLLOW BEDTIME ROUTINES AND RITUALS.** You can shorten each step significantly and potentially eliminate nightlong frustrations due to the change. If your child is away from home for a night or two you may see old sleeping patterns emerge. Even in a temporary new environment, routines may help. Upon returning home the bedtime routine will continue to be effective, though the excitement from the change may take a night or more to fade depending on your child and how long you have been away.