HAUTE AUTORITÉ DE SANTÉ

RECOMMENDING
BEST PRACTICES

RECOMMENDATION

Autism Spectrum Disorder: interventions and life pathways for infants, children and adolescents

Adopted by the HAS Board on 8 January 2026

Good practice guidelines are defined in the health field as systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances.

Good practice guidelines are rigorous summaries of the state-of-the-art and scientific data at a given time, described in the evidence report. They do not exempt healthcare professionals from exercising discretion in the patient's treatment; this must be the treatment considered to be most appropriate on the basis of their own findings and the patient's preferences.

This good practice guideline was developed according to the method summarised in the evidence report and, in the HAS methodological guide available online: Development of good practice guidelines – Formal consensus method.

The objectives of this guideline, the population and the professionals concerned by its implementation are summarised in the description of the publication and described in detail in the evidence report.

The latter and the guideline summary can be downloaded from www.has-sante.fr.

Grades of recommendations

A	**Established scientific evidence** Based on studies with a high level of evidence (level of evidence 1): randomised controlled trials with high power and without major bias or meta-analysis of randomised controlled trials, decision analysis based on well conducted studies.
B	**Scientific presumption** Based on scientific presumption provided by studies with an intermediate level of evidence (level of evidence 2) such as low power randomised controlled trials, well conducted non-randomised controlled studies, cohort studies.
C	**Low level of evidence** Based on studies with a lower level of evidence such as case-control studies (level of evidence 3), retrospective studies, case-series studies, comparative studies with major biases (level of evidence 4).
EC	**Expert consensus** In the absence of studies, the recommendations are based on agreement between experts in the working group after consultation of the review group. The absence of grading does not mean that the recommendations are not relevant and useful. However, it should prompt additional studies.

This document and its bibliographic reference are available to download at www.has-sante.fr

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Description of the publication

Title	Autism Spectrum Disorder: interventions and life pathways for infants, children and adolescents
Working method	Recommandation par consensus formalisé [formalised consensus-based guideline]
Objective(s)	For children, adolescents and young adults with Autism Spectrum Disorder (ASD): to improve their overall functioning; to reduce associated health conditions; to support the development of their ability to communicate, make choices and take decisions; to promote independence in activities of daily living; to foster their educational and academic learning; to support their inclusion in an appropriate vocational pathway; to ensure a satisfactory quality of life; to enhance their social participation and prepare them to exercise full and active citizenship. For healthcare professionals and medico-social teams: - to identify the most appropriate interventions, taking into account the findings of the assessment of the child's or adolescent's functioning (notably according to the level of ASD severity and the presence of other neurodevelopmental disorders – especially a diagnosis of intellectual disability and attention deficit hyperactivity disorder), their life choices and preferences, and considering existing environmental facilitators and barriers; - to define the modalities for effective implementation and any necessary adaptations (intensity, duration, family involvement, educational adjustments, etc.); - to incorporate additional targeted or complementary actions in order to address specific needs of the child or their environment; - to plan coordination between the various interventions and the necessary partnerships in order to ensure the consistency of the overall care pathway and to prevent any risk of discontinuity in care.
Targets concerned	Population: all children and adolescents up to the age of 20 with Autism Spectrum Disorder (ASD) from the point at which the diagnosis is established; children with suspected ASD confirmed during a dedicated identification consultation in primary care, pending specialist consultation with second-line professionals. Professionals: - child and adolescent psychiatrists, paediatricians or paediatric neurologists, general practitioners, school doctors in the French national education system, forensic medical experts, and maternal and child health physicians; - psychologists; - rehabilitation professionals: speech and language therapists, psychomotor therapists, occupational therapists, physiotherapists; - social care professionals: specialist educators, early years educators, assistant educators, healthcare support workers, care assistants, educational and social support workers, social workers, family and social economy advisers, etc.; - sports educators and adapted physical activity instructors; - specialist nurses: nursery nurses, advanced practice nurses specialising in psychiatry and mental health; - coordinating professionals (e.g. special educational needs coordinators, coordinators of multidisciplinary teams within departmental disability centres, etc.);

	- senior healthcare staff, managerial and leadership personnel within health and social care organisations.
Requester	Self-referral
Sponsor(s)	*Haute Autorité de santé* (HAS) [French National Authority for Health]
Project management	Coordination: Ms Muriel Dhénain, Project Manager, HAS Department for Good Clinical Practice (Head of Department: Dr Morgane Le Bail); Mr Jonathan Biglietto, Project Manager, HAS Guidelines Department (Head of Department: Ms Manuela Cheviot) Secretary: Ms Sladana Praizovic.
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Declaration of interests	The members of the working group have submitted their public declarations of interest to the HAS. They are available to view on the https://dpi.sante.gouv.fr website. They were reviewed according to the analysis grid of the HAS guidelines for the declaration of interests and management of conflicts of interest. In its analysis, the HAS also included the "Transparence-Santé" database, which requires manufacturers in the healthcare sector to publish the agreements, remuneration and benefits that bind them to players in the healthcare sector. The interests declared by the members of the working group and the information included in the "Transparence-Santé" database were deemed to be compatible with the participation of the experts in the working group.
Validation	Version dated: 8 January 2026
Updating	
Other formats	Evidence report; key messages summary.

Contents

Abbreviations and acronyms 8

Introduction 10

Foreword 12

Recommendations 15

1. Assessment of functioning 16

1.1. Procedures for carrying out the functional assessment as part of the child/adolescent's follow-up 16

1.1.1. A multidisciplinary assessment 16

1.1.2. A regular assessment 17

1.1.3. An assessment based on functional evaluation and the sharing of observations 17

1.2. Domains requiring regular monitoring for all autistic children/adolescents 18

1.3. Components of the personalised intervention plan 18

2. Family support and training, taking account of their experiential expertise 20

2.1. Impact on parents' quality of life 21

2.2. Impact on their children's quality of life 22

3. Interventions 23

3.1. Comprehensive developmental and behavioural interventions 23

3.1.1. Early interventions (Table 2) 24

3.1.2. Interventions during childhood and adolescence 26

3.1.3. Non-recommended interventions 26

3.2. Interventions by functional domain 27

3.2.1. Domain of independence in activities of daily living 27

3.2.2. Communication interventions 28

3.2.3. Interventions focused on social skills 29

3.2.4. Interventions focused on sensory processing and motor skills 30

3.3. Environmental adaptations 31

3.3.1. In the spatial environment 31

3.3.2. Temporal organisation 32

3.3.3. In terms of information 32

3.3.4. In terms of environmental adaptations 32

3.4. Technical aids 33

3.4.1. Remote activities: approaches and monitoring 33

3.4.2. Tele-expertise 33

3.4.3. Digital tools 34

3.4.4. Research perspectives 34

4. Education, schooling and independence 35

4.1. Schooling 35

4.2. Coordination and partnership on schooling for comprehensive and coherent support 37

4.3. Support and training for professionals in schools and vocational training settings 37

4.4. Physical activity and sport, leisure, and culture 38

4.4.1. Physical activity and sport 38

4.4.2. Access to leisure, holidays and culture 39

5. Monitoring in primary and specialist care 40

5.1. Physical and mental health monitoring 40

5.1.1. Foundations of physical and mental health monitoring 40

5.1.2. With a view to health prevention 41

5.1.3. Focus: sleep disorders 41

5.2. Preparation for consultations with healthcare professionals 42

5.2.1. Domains of awareness regarding the specific features of autism recommended for healthcare professionals 42

5.2.2. Recommended approach to ensure appropriate care and support the active participation of the autistic child or adolescent and their family 42

5.2.3. Recommended implementation of care during consultations 43

5.3. Medications and other biomedical interventions for co-occurring conditions 43

5.3.1. General principles for pharmacological interventions in autism spectrum disorder 44

5.3.2. Information, monitoring and involvement of autistic children or adolescents, their families and the professionals supporting them 44

5.3.3. Prescription and monitoring of psychotropic treatments 45

5.3.4. Melatonin prescription 45

5.3.5. Prescription of diets 46

6. Adolescence and transition to adulthood 47

6.1. Life course: continuity of care and appropriate interventions 47

6.2. Risks of psychiatric disorders: prevention and monitoring 47

6.3. Late diagnosis 48

***7.* Autistic individuals with intensive needs – profound autism 49**

7.1. Definition of the notion of autistic individuals with intensive needs – profound autism 49

7.2. Principles of support for autistic individuals with intensive needs – profound autism 50

7.3. Points of vigilance for public health actions 50

8. Support for relational, emotional and sexual life 51

8.1. For autistic children and adolescents: 51

8.2. By the professionals supporting them, in collaboration with families 51

9. Specific case of support within child protection services 53

9.1. Avoiding diagnostic errors and promoting an appropriate pathway 53
9.2. Training and support for child protection professionals and foster families 53
9.3. Adaptation of environments 54

10. Prevention and responses to challenging behaviours 55
10.1. Challenging behaviours: prevention, support and management 55
10.2. Implementation of resolution strategies for challenging behaviours and crises in order to avoid breakdowns in support 56

11. Role and training of professionals 57
11.1. Training and supervision of professionals 57
11.2. Role of professionals in care pathways and their coordination 58
11.3. Promoting clinical research 62

Glossary 63

Table of annexes 65

Participants 83

Abbreviations and acronyms

ABA	Applied Behaviour Analysis
AESH	Accompagnant des élèves en situation de handicap (Special educational needs support assistant)
APA	Adapted physical activity
AAC	Augmentative and Alternative Communication
CAMSP	Centre d'action médico-sociale précoce (Early childhood health and social care centres)
ICF	International Classification of Functioning, Disability and Health
CMP	(Centre médico-psychologique) Child and adolescent mental health centre
CRA	Centre de ressources autisme (Autism resource centre)
CRTLA	Centre de référence des troubles du langage et des apprentissages (Specialist centre for language and learning disorders)
DI TND	Délégation interministérielle à la stratégie nationale pour les troubles du neurodéveloppement (Inter-ministerial Delegation for the National Strategy on Neurodevelopmental Disorders)
EIBI	Early Intensive Behavior Intervention
ESDDA	Échelle simplifiée d'évaluation de la douleur chez les personnes dyscommunicantes (Simplified pain assessment scale for non-communicating individuals)
ESS	Équipe de suivi de la scolarisation (Schooling monitoring team)
ESSMS	Établissement ou service social et médico-social (Social and medico-social facility or service)
EVRAS	Éducation à la vie relationnelle, affective et sexuelle (Relational, emotional and sexual education)
GED-DI	Grille d'évaluation de la douleur – déficience intellectuelle (Pain assessment grid for individuals with intellectual disability)
GEM	Groupes d'entraide mutuelle (mutual help groups)
GNCRA	Groupement national des centres de ressources autisme (National network of autism resource centres)
HAS	*Haute Autorité de santé* [French National Authority for Health]
IME	Institut médico-éducatif (Specialist educational institute for children with disabilities)
JASPER	*Joint Attention, Symbolic Play, Engagement, and Regulation*
MDPH	Maison départementale des personnes handicapées (Departmental disability centre)
NDBI	Naturalistic Developmental Behavioural Interventions
PACT	*Pediatric Autism Communication Therapy*
PCO	Plateforme de coordination et orientation (Coordination and referral platform)
PCPE	Pôles de compétences et de prestations externalisées (Specialised support and outreach service hubs)
PMI	*Parent-Mediated Interventions*
PPC	Plan personnalisé de compensation (Personalised compensation plan)
PPS	Projet personnalisé de scolarisation (Personalised schooling plan)
SESSAD	Service d'éducation spéciale et de soins à domicile (Special education and home care service)
CBT	Cognitive behavioural therapies

ADHD	Attention Deficit Hyperactivity Disorder
ID	Intellectual disability
TEACCH	Treatment and Education of Autistic and Related Communication-Handicapped Children
ASD	Autism spectrum disorder
UE	Unité d'enseignement (Teaching unit)
UEE	Unité d'enseignement externalisée (Outreach teaching unit)
UEEA	Unité d'enseignement élémentaire autisme (Autism-specific primary teaching unit)
UEMA	Unité d'enseignement maternelle autisme (Autism-specific nursery teaching unit)
ULIS	Unité localisée pour l'inclusion scolaire (Localised inclusive education unit)

Introduction

Referral

The French National Authority for Health (HAS), on a self-referral basis, chose to address the topic: "Autism Spectrum Disorder (ASD): interventions and life pathways for infants, children and adolescents", as included in its 2022 work programme. This constitutes an update of the good practice guideline (GPG) entitled "Autism and other pervasive developmental disorders: coordinated educational and therapeutic interventions in children and adolescents {Haute Autorité de santé, 2012 #2538}, jointly published by HAS and the former ANESM in 2012.

The development method adopted was the "formal consensus-based guidelines" approach.[1]

In light of current practice, the title has been extended to include the infant population.

Implications and objectives of the good practice guideline

The following challenges must be met.

- ➔ For professionals:
  - improve and harmonise the provision of support and healthcare practices, taking into account the specific characteristics of autistic children;
  - influence children's developmental trajectories through early intervention;
  - promote the generalisation of learning by involving parents in their child's development;
  - ensure improved coordination of the various interventions;
  - prevent any disruption in care and support pathways, with particular attention at the transition from adolescence to adulthood.
- ➔ For children and adolescents:
  - support their development and learning in areas affected by ASD through the implementation of appropriate interventions, incorporated into an evolving life pathway allowing for self-determination, within a more inclusive society (sport, culture, leisure).
- ➔ For parents, legal representatives, siblings and family carers:
  - co-construct with them the various plans (care, support, education) and to develop co-intervention;
  - prevent caregiver burnout and provide appropriate forms of support in order to preserve family balance and the quality of intra-family relationships.

The objective of this good practice guideline is to improve the quality of interventions offered to autistic children and adolescents, both in healthcare and in health and social care services, in order to ensure a coherent and high-quality life pathway, and to promote access to learning and inclusive environments.

The list of selected questions is presented in **Annexe 1**.

Population concerned

The population covered by this topic includes:

[1] Haute Autorité de santé. Élaboration de recommandations de bonne pratique. Méthode "Recommandations par consensus formalisé". Saint-Denis La Plaine: HAS; 2015. Haute Autorité de santé – Recommandations par consensus formalisé (RCF) (has-sante.fr).

- all children and adolescents up to the age of 20 with ASD, from the point at which the diagnosis is established;
- children with suspected ASD confirmed during a dedicated identification consultation in primary care, pending specialist consultation with second-line professionals.

Professionals concerned

The professionals concerned by this topic include:

- child and adolescent psychiatrists, paediatricians or paediatric neurologists, general practitioners, school doctors in the French national education system, forensic medical experts, and maternal and child health physicians;
- psychologists;
- rehabilitation professionals: speech and language therapists, psychomotor therapists, occupational therapists, physiotherapists;
- social care professionals: specialist educators, early years educators, assistant educators, healthcare support workers, care assistants, educational and social support workers, social workers, family and social economy advisers, etc.;
- sports educators and adapted physical activity instructors;
- specialist nurses: nursery nurses, advanced practice nurses specialising in psychiatry and mental health;
- coordinating professionals (e.g. special educational needs coordinators, coordinators of multidisciplinary teams within departmental disability centres, etc.);
- senior healthcare staff, managerial and leadership personnel within health and social care organisations.

The good practice guideline may also be relevant to:

- professionals working with children and adolescents in early childhood, educational, extracurricular, social and cultural sectors, although this document does not cover their specific practices;
- teachers and trainers involved in the field of ASD in the initial and ongoing training of doctors, allied health professionals, psychologists, educators and specialist teachers.

The other intended users of the good practice guideline include:

- autistic minors or young adults who wish to better understand the types of interventions likely to be offered to them;
- parents, relatives concerned, legal representatives responsible for making decisions affecting the life pathways of the patients concerned, and family caregivers who provide support in patients' daily lives and administrative processes;
- volunteers working within associations engaged in the autism field.

Foreword

The good practice guideline (GPG) published in 2012 by the French National Authority for Health (HAS) and the former National Agency for the Evaluation and Quality of Health and Social Care Establishments and Services (ANESM) marked a key stage in structuring the provision of high-quality support for children and adolescents with Autism Spectrum Disorder (ASD). These guidelines set out the principles underpinning educational and therapeutic interventions. They involve a wide range of stakeholders, in particular the family, the individual concerned, and professionals working in the social, health and social care, and healthcare sectors. Advances in scientific knowledge and professional practice since 2012 have led to the present update of these guidelines.

A shift in understanding autism spectrum disorder

The transition from DSM-IV to DSM-5 in 2013 led to the replacement of the previously used term "pervasive developmental disorders" (PDD) with "autism spectrum disorder" (ASD), reflecting a change in definition to describe a continuum of clinical manifestations and needs. The diagnostic triad (impairments in communication, social interaction and restricted or repetitive behaviours) has evolved into a dyad, encompassing the combination of difficulties in social communication with repetitive or restricted patterns of behaviour. Furthermore, DSM-5 introduces an assessment of the levels of support required. ASD falls within the category of neurodevelopmental disorders (NDD).

A better understanding of developments

The prevalence of ASD is currently estimated, with considerable variation across countries and studies, at around 1 to 2% of the population.

At the same time, there is growing awareness of the importance of identifying and diagnosing disorders frequently associated with ASD, such as other neurodevelopmental, psychiatric and somatic disorders, particularly neurological conditions.

This observation highlights the importance of prevention, particularly among people with communication difficulties and those entering adolescence or adulthood.

National strategies: a framework for updating the guidelines

Since 2012, successive national plans and strategies implemented in France have supported developments in public policy on ASD.

The third Autism Plan (2013–2017) emphasised the roll-out of best practices and focused on the development of early diagnosis systems, which led to the establishment of coordination and referral platforms in 2019.

The national strategy for autism within neurodevelopmental disorders (2018–2022) established five centres of excellence (Stras&nd (Strasbourg), IMind (Lyon), CEAND (Montpellier), EXAC-T (Tours), Inovand (Paris)) and one scientific interest group on ASD and neurodevelopmental disorders.

The National Strategy for Neurodevelopmental Disorders (2023–2027) has built on this momentum.

The main changes in these recommendations since 2012 concern the following areas:

- the need for early intervention as soon as the first concerns about development arise during early childhood, childhood or adolescence;
- recognition of the heterogeneity of support needs, which may be very substantial;
- the performance of ongoing assessments of functioning throughout life;
- the importance of involving and supporting families;

- the importance of involving autistic children and adolescents in their own care and support pathways (daily life, health monitoring, activities, relationships and sexuality, etc.), by adapting to their functioning and mode of communication and supporting them in making choices;
- the diversification of educational provision;
- consideration of associated conditions and specific needs during the transition to adolescence and adulthood;
- the growing role of digital technologies in support.

Aspects of the 2012 good practice guidelines that remain relevant are included in the text of the 2025 guidelines and marked as such [GPG 2012].

French National Authority for Health (HAS) guidelines: an evolving framework to promote support for autistic people

Since 2012, HAS has expanded its body of good practice guidelines relevant to the provision of support for autistic people.

In 2016 and 2017, it published guidance on "Challenging behaviours" (Part 1: prevention strategies; Part 2: intervention strategies; Part 3: low-arousal and de-escalation spaces (HAS/ex-ANESM)[2]) , in addition to the guide entitled "Quality of Life: Disability, Somatic Conditions and Painful Phenomena."[3]

In December 2017, HAS adopted a guideline entitled "Autism Spectrum Disorder: Interventions and Life Pathways in Adults".[4]

In February 2018, it updated the 2005 guidelines by adapting the guideline "Autism Spectrum Disorder: Warning Signs, Identification, Diagnosis and Assessment in Children and Adolescents".[5]

In March 2020, HAS published a guideline entitled "Neurodevelopmental Disorders – Identification and Referral of At-Risk Children".[6]

In November 2020, it published a guideline on "Supporting Individuals With Profound and Multiple Disabilities in their Specific Needs".[7]

In September 2022, HAS published a guideline entitled "Supporting individuals with intellectual disability – Part 1".[8]

In September 2024, it published a guideline on "Neurodevelopmental disorder/ADHD: diagnosis and therapeutic interventions for children and adolescents".[9]

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[2] https://www.has-sante.fr/jcms/c_2834964/fr/les-comportements-problemes-au-sein-des-etablissements-et-services-accueillant-des-enfants-et-adultes-handicapes
https://www.has-sante.fr/jcms/c_2833763/fr/les-espaces-de-calme-retrait-et-d-apaisement

[3] "Qualité de vie : handicap, les problèmes somatiques et les phénomènes douloureux" Haute Autorité de Santé - Qualité de vie : handicap, les problèmes somatiques et les phénomènes douloureux

[4] "Trouble du spectre de l'autisme : interventions et parcours de vie de l'adulte"https://www.has-sante.fr/jcms/c_2006477/fr/trouble-du-spectre-de-l-autisme-interventions-et-parcours-de-vie-de-l-adulte

[5] "Trouble du spectre de l'autisme : signes d'alerte, repérage, diagnostic et l'évaluation chez l'enfant et l'adolescent" https://www.has-sante.fr/jcms/c_468812/fr/trouble-du-spectre-de-l-autisme-signes-d-alerte-reperage-diagnostic-et-evaluation-chez-l-enfant-et-l-adolescent

[6] "Troubles du neurodéveloppement – Repérage et orientation des enfants à risque" https://www.has-sante.fr/jcms/p_3161334/fr/troubles-du-neurodeveloppement-reperage-et-orientation-des-enfants-a-risque

[7] "L'accompagnement de la personne polyhandicapée dans sa spécificité"https://www.has-sante.fr/jcms/p_3215404/fr/l-accompagnement-de-la-personne-polyhandicapee-dans-sa-specificite

[8] "L'accompagnement de la personne présentant un trouble du développement intellectuel (TDI) – Volet 1" https://www.has-sante.fr/jcms/p_3237847/fr/l-accompagnement-de-la-personne-presentant-un-trouble-du-developpement-intellectuel-tdi-volet-1

[9] Trouble du neurodéveloppement/TDAH : diagnostic et interventions thérapeutiques auprès des enfants et adolescents https://www.has-sante.fr/jcms/p_3302482/fr/trouble-du-neurodeveloppement/tdah-diagnostic-et-interventions-therapeutiques-aupres-des-enfants-et-adolescents

In addition, HAS is currently developing guidelines on supporting the development of self-determination and empowerment within social and medico-social facilities or services (ESSMS).

The principles established in 2012 – namely that ASD interventions should be early, comprehensive, based on a coherent and coordinated care pathway, and grounded in educational, behavioural and developmental approaches (Grade B in 2012) – remained valid in 2025.

Given the limited evidence available in the literature, further research is required, particularly in clinical, epidemiological and interventional fields.

From an epidemiological perspective, it is reiterated that there is no evidence of a link between ASD and:

- vaccination (including measles, mumps and rubella);
- paracetamol use during pregnancy;
- screen overexposure, although this does not preclude their use.

Substantial efforts to scale up professional training (across the healthcare, social care, and health and medico-social sectors), and to raise awareness in all areas of life (education, training, leisure, culture, sport, employment, housing, etc.) are essential in order to improve intervention, action and support.

The steering group chose, by common agreement, to refer to the children and adolescents concerned as "autistic children" or "autistic adolescents".

The expression "Autism Spectrum Disorder" (ASD) is used when referring to the condition itself.

Unless the grade of the guideline is specified, all of the following recommendations are based on expert consensus. They have been developed on the basis of scientific evidence, which includes bibliographical references and discussions during meetings of the steering and rating groups.

Recommendations

1. Assessment of functioning

Key message

The assessment of functioning required for monitoring autistic children and adolescents and for defining their personalised intervention plan is multidimensional, multidisciplinary, regular, and based on observations carried out and shared by parents and professionals.

In 2026, diagnostic assessment remains the first stage of therapeutic interventions.

Assessments of the child's/adolescent's development and health status are intended to define and adjust the interventions proposed within the framework of a personalised intervention plan, and to ensure the consistency of that plan in light of updated knowledge [GPG 2012].

All assessments are centred on the child/adolescent. They take account of their unique characteristics as well as those of their family and are conducted in close collaboration with them. All information must be communicated to them both orally and in writing, in an accessible manner. The objectives and the assessment tools used are explained to them [GPG 2012].

Before initiating this process, the guidelines [GPG 2012] recommend:

- organising a discussion with the child/adolescent, adapted to their communication abilities, and with their parents, in order to understand their expectations and their level of satisfaction regarding the previously implemented or planned intervention plan;
- ensuring that the initial assessment has been carried out in accordance with current recommendations and, where necessary, undertaking any examinations that have not yet been completed;[10]
- requesting, with the family's consent and in accordance with professional ethical standards, the transfer of assessments previously carried out in the same domains by another team or professional.

The implementation of interventions may begin even before all initial assessments have been completed, as soon as a developmental disorder is observed [GPG 2012].

The diagnostic process must be immediately linked to the implementation of interventions and requires coordination between the diagnostic teams and the intervention teams [GPG 2012].

1.1. Procedures for carrying out the functional assessment as part of the child/adolescent's follow-up

1.1.1. A multidisciplinary assessment

Updating the personalised plan for coordinated educational and therapeutic interventions means monitoring the child's or adolescent's developmental progress in their various areas of development. For this reason, the assessment is multidisciplinary and, for all autistic children and/or adolescents, draws on medical, psychological, paramedical and educational expertise [GPG 2012].

[10] Cf. Autism Spectrum Disorder: Warning Signs, Identification, Diagnosis and Assessment in Children and Adolescents – HAS 2018.

This multidisciplinary assessment, carried out by the usual team of practitioners, is recommended for the implementation of educational and therapeutic interventions (definition or updating of the personalised intervention plan) [GPG 2012].

1.1.2. A regular assessment

To adapt the personalised intervention plan, it is recommended that an assessment be carried out by experienced professionals trained in assessing the various domains of development at least annually for every autistic child or adolescent. This assessment is systematically followed by a case review meeting [GPG 2012].

1.1.3. An assessment based on functional evaluation and the sharing of observations

Any assessment aimed at monitoring the development of an autistic child or adolescent systematically includes a physical/somatic examination, structured clinical observations, and informal observations of the child's/adolescent's functioning and participation, conducted continuously by parents and professionals during the proposed interventions. It also takes account of assessments carried out within the framework of the personalised education plan by teaching teams, as well as reviews conducted during meetings of schooling monitoring teams led by the designated coordinating teacher [GPG 2012].

The structured clinical observations required to update the personalised plan are functional assessments that are straightforward to implement and enable a description of the child's/adolescent's functioning, participation and emerging abilities. Their frequency must be at least annual for every autistic child or adolescent, and may be more frequent in certain domains [GPG 2012]. The main assessment tools for children and adolescents are presented in **Table 3, Table 4, Table 5, Table 6, Table 7** (cf. GPG 2018).

However, annual structured clinical observations alone are insufficient to adjust the functional objectives of the interventions, to monitor their effectiveness for a given child/adolescent, and to ensure the generalisation of the acquired skills. They must therefore be complemented by continuous informal observation of the child's/adolescent's functioning and participation across their different living environments and during the interventions delivered by professionals [GPG 2012]. The tools recommended for structuring clinical observations are presented in **Table 8** and **Table 9** [GPG 2012].

It is recommended that this informal observation be discussed regularly with the family and, where the family agrees, shared between professionals. The sharing of observations between professionals may take different forms: team meetings, face-to-face or telephone conversations, written records or session reports made available to other professionals (shared or consultable files, in compliance with the ethical standards of each profession) [GPG 2012].

The sharing of observations between professionals is organised as follows: regular formalised reporting, case review meetings, and supervision by an experienced professional (preferably monthly and at least quarterly). These frequencies should take account of the needs of the professional team and of the autistic children or adolescents concerned.

1.2. Domains requiring regular monitoring for all autistic children/adolescents

The heterogeneity of clinical profiles and developmental trajectories of autistic children and adolescents requires regular assessment, at least annually, carried out by the intervention team, covering all the domains listed in Table 1 and providing a synthesis within an overall view of the child's/adolescent's development [GPG 2012].

Table 1. Domains requiring regular assessment

ICF*	Domains
Functioning	communication and language social interactions or socialisation cognitive functioning sensory and motor functioning emotions and behaviour somatic health
Activities and participation	independence in daily activities
	learning, particularly academic and pre-vocational
Environmental factors	family environment material environment

* ICF: International Classification of Functioning, Disability and Health

The assessments include evaluation of the child's/adolescent's functioning and development by domain, together with continuous observation to monitor the effectiveness of interventions for that individual [GPG 2012] (cf. **Table 3, Table 4, Table 5, Table** 6**, Table 7**).

1.3. Components of the personalised intervention plan

The child's/adolescent's plan comprises essential and interrelated components: educational, pedagogical and therapeutic. These different components should be adapted to suit to each child/adolescent, their strengths, needs and developmental trajectory [GPG 2012].

The personalised plan should therefore specify [GPG 2012]:

- the functional objectives to be achieved in each of the targeted domains following assessment;
- the means proposed (types of activities, techniques, etc.) to achieve these objectives;
- the professionals responsible for implementation (in the educational, pedagogical and therapeutic sectors);
- the timelines for reviewing these objectives.

Each professional contributing to the implementation of the personalised plan defines concrete criteria for the interventions they carry out, which will enable them to assess whether the objectives have been achieved and are operational, and, where necessary, to adjust the intervention objectives if they prove too ambitious or insufficiently ambitious for the child/adolescent [GPG 2012].

Although specific domains of intervention are identified, they are intrinsically interlinked, interactive and complementary. The interventions must therefore be implemented in a coherent manner [GPG 2012].

Assessment generally leads to the identification of needs requiring the involvement of professionals from different disciplines, and sometimes from different organisations or modes of practice. The expected contribution of each participant, as well as the coordination arrangements, must be specified in the personalised coordinated intervention plan [GPG 2012].

Meeting these children's and adolescents' needs requires consultation among stakeholders (primarily the parents, with the involvement of the autistic child or adolescent) in order to develop a shared vision and to ensure that the services and interventions offered are as consistent and timely as possible [GPG 2012].

Particular attention should be paid to this need for early and coherent intervention when the involvement of professionals required to implement coordinated interventions for the child or adolescent involves a referral decision by the Commission for the Rights and Autonomy of People with Disabilities (CDAPH) and the definition of a personalised compensation plan [GPG 2012].

2. Family support and training, taking account of their experiential expertise

Key message

Support and training for parents are essential and must take account of their experiential expertise. This encompasses a range of approaches, including guidance, psycho-education, therapeutic education, parent support groups, mutual aid and social support groups, peer-led support for the families of people concerned, and respite schemes.

The combination of family support and training with interventions proposed for the child is a key factor in creating an environment that is more conducive to the development of autistic children and to improving families' quality of life.

It is recommended that careful consideration be given to how parents and their children are received and supported. These arrangements should be adapted to the age of the child or adolescent and incorporated, in the form of protocols, into the institutional or service plan [GPG 2012].

Each family develops its own modes of interaction. It is therefore important to consider the diversity and complexity of family situations (cultural, social and economic), to clarify, where necessary, issues relating to parental responsibility[11] separated parents, blended families, single parents, siblings, guardians, etc.), and to acknowledge any legal decisions or orders concerning the child/adolescent. Unless otherwise determined by a court decision, it is recommended to promote and maintain contact with both parents [GPG 2012].

It is recommended that the personalised intervention plan be co-constructed by parents and professionals, in order to obtain shared agreement among all stakeholders (objectives, proposed means, implementation arrangements) [GPG 2012].

Efforts should be made to ensure that parents and their child understand the objectives of the interventions, the means implemented (roles of each participant, strategies used, etc.), and that parental consent is obtained, in accordance with the principles set out in the Law of 4 March 2002 on patients' rights and the quality of the healthcare system, and the Law of 2 January 2002 reforming social welfare and socio-medical action [GPG 2012].

It is recommended to encourage parents to speak freely, listen to their needs and offer them various forms of support [GPG 2012].

Particular attention should also be paid to signs of distress and requests for support expressed by siblings, and a variety of support options should be offered: individual psychological support, "parents-children-siblings" themed groups, discussion groups, organisation of joint activities with siblings, etc. These options should not be imposed [GPG 2012].

Parents are advised to be particularly cautious regarding interventions presented by professionals or organisations either as a means of completely eliminating the symptoms of ASD or even completely

[11] Throughout this guideline, reference is made to situations in which parental responsibility is exercised jointly by the child's father and mother (Article 371-1 of the French Civil Code). In certain situations, however, the arrangements for joint parental responsibility may be modified, particularly in cases of parental separation or of a change in residence of one parent. In other cases, parental responsibility may be delegated by the parents, or partially or wholly withdrawn by a judge. A guardian may then be appointed; this also applies in the event of the parents' death, or where the person concerned has reached the age of majority, which marks the end of parental responsibility but places them under a guardianship order. Depending on the circumstances, it may therefore be appropriate to inform and involve the holders of parental authority or the guardians of the minor or the protected adult.

curing their child, or as a method requiring exclusive use of that support, as discontinuing interventions may pose a risk or lead to a loss of opportunities for the individual (e.g. discontinuation of treatments for associated conditions[12]) [GPG 2012].

In light of evidence of effectiveness and professional experience, parental involvement in comprehensive interventions is recommended to ensure consistency in interactions with the child (Grade B) [GPG 2012].

2.1. Impact on parents' quality of life

Support for parents has a positive impact on their quality of life. It reduces parental stress, enhances their sense of competence, and improves overall family dynamics.

Parental support includes parental guidance, psychoeducation, parenting skills training, therapeutic patient education, parent support groups, mutual aid and social support groups, caregiver training, and various respite services (for example, short-term care, in-home respite support, or respite holiday programmes).

Parents of autistic children and adolescents are included within caregiver support policies. As such, they benefit from specific information (notably through autism resource centres, departmental disability centres, coordination and referral platforms, family associations, etc.).

It is recommended to:

- offer parental guidance (for example, see Guidance on Intellectual Disability and Neurodevelopmental Disorders, PACT and Jasper) to parents as soon as autism is suspected;
- provide specific support to help parents manage the key post-diagnostic stage, notably access to information and rights;
- actively offer families support tailored to their needs and expectations (for example, caregiver training provided by autism resource centres, and free information resources and educational materials provided by the national autism network); to take parental stress into account in order to prevent the risk of burnout;
- help parents better understand the functioning of their autistic child, regardless of age;
- explain the interventions to be implemented in collaboration with professionals;
- value and strengthen parents' educational skills so that they can be adapted to their child's specific needs in daily life;
- provide parents with practical tools through educational programmes and hands-on training, enabling them to acquire the knowledge needed to support their child;
- offer parents social, emotional, informational and material support, and to identify and address families' respite needs;
- systematically include parental support as an essential component of the child's pathway, ensuring the continuity and coherence of support;
- inform families about local services and resources (in particular via autism resource centres, departmental disability centres, coordination and referral platforms for neurodevelopmental disorders, family associations, mutual aid groups, independent practitioners, etc.);
- train professionals in reciprocal knowledge and skill sharing techniques with parents.

[12] "Pour un accompagnement de qualité des personnes avec autisme ou autres troubles du développement" ("Towards High-Quality Support for People With Autism or Other Developmental Disorders", ANESM, January 2010 (Chapter 2, paragraph 2.4 "Attirer la vigilance des personnes et des familles sur les risques de dérives liées à certaines pratiques" ("Raising awareness among individuals and families of the risks associated with certain practices").

2.2. Impact on their children's quality of life

Parental support promotes consistency in interventions, the generalisation of learning in everyday life, and contextual adaptations, while enabling the prevention and management of challenging behaviours. It is recommended to:

- involve parents in assessments of functioning and to explain their role in selecting interventions in the cognitive, communication, sensory, motor and emotional domains;
- inform, train and support parents with regard to:
  - the monitoring of their child's health (e.g. oral health, sleep, bowel function);
  - environmental adaptations (particularly sensory and temporal structuring);
  - strategies for preventing and managing challenging behaviours.

3. Interventions

Key messages

The recommended comprehensive interventions are developmental and behavioural in nature. They should begin as early as possible – as soon as the first diagnostic concerns are raised – and continue throughout childhood and adolescence, with increased vigilance during the transition to adulthood.

The interventions concern multiple functional domains, such as independence in daily living, communication, social skills, sensory processing and motor skills.

All intervention plans systematically include a personalised component aimed at improving communication in the autistic child or adolescent. They may be implemented without preconditions. Where indicated, Augmentative and Alternative Communication (AAC) – a key component of the overall plan – should be introduced from the earliest stages of support.

Consideration should be given to adapting the environments in which autistic children and adolescents live (physical spaces, temporal organisation, information) in order to align them with their individual needs.

Technical aids can be used to facilitate the remote monitoring of specialist interventions. These include tele-expertise and digital tools.

3.1. Comprehensive developmental and behavioural interventions

Key principles:

- respect the preferences of parents and autistic children or adolescents, family priorities, and the principles of respectful care;
- take account of the specific characteristics of each child or adolescent and their family;
- include objectives relating to the generalisation of learning in different contexts of daily life, so that the children or adolescents can use their skills in a variety of situations;
- combine group-based and individual sessions.

Behavioural and developmental interventions are grounded in several theoretical frameworks, including learning theory [GPG 2012].

The aims of these interventions [GPG 2012] are to:

- provide the children and their families with a secure relational environment;
- promote the development of the children/adolescents in functional domains (communication and language, social interaction, sensory and motor functioning, cognitive, emotional and affective development), as well as their social and educational participation, autonomy, independence, learning and adaptive skills;
- reduce environmental barriers that exacerbate their disability;
- contribute to their well-being and personal fulfilment.

Accordingly, it is recommended [GPG 2012] to:

- define and prioritise the proposed interventions based on the results of assessments in the different domains of functioning and social participation of the children/adolescents;

- monitor and assess the proposed interventions on the basis of continuous assessment of the children's/adolescents' development, involving both these individuals and their parents;
- adapt the interventions according to the child's/adolescent's age and developmental level.

Regardless of their age, the intensity and content of interventions must be determined in line with ethical considerations aimed at limiting the risks of both under-stimulation and over-stimulation [GPG 2012].

If no clear progress is observed after several months, the choice of approaches, their implementation, and the objectives, duration or frequency of interventions should be reviewed and adjusted, following discussions between the family and professionals, and, if necessary, after consultation with a specialist team or an autism resource centre [GPG 2012].

3.1.1. Early interventions (Table 2)

It is recommended to initiate early intervention in autism upon the appearance of the first warning signs,[13] without awaiting confirmation of the diagnosis, and to continue the intervention once the diagnosis has been confirmed (cf. Diagnostic GPG, HAS 2018).

Early intervention encompasses any developmental and behavioural intervention covering physical, sensory, motor, socio-emotional, cognitive and communication domains.

It includes direct interventions with the infant or child, the provision of parental guidance and support for early childhood professionals and settings, such as early years childcare services, childminders and nursery schools).

In the framework of early intervention, it is recommended to offer infants and children with a confirmed risk or diagnosis of ASD at least 10 hours per week of interventions delivered by professionals specifically trained in developmental and behavioural approaches and in the provision of parental guidance. In addition to these 10 hours per week, it is recommended to offer parent-mediated activities at home in addition to interventions delivered by early childhood and educational professionals.

For autistic children under six years of age, priority should be given to early interventions supported by evidence of effectiveness capable of influencing developmental trajectories. These include early behavioural and/or developmental interventions such as Early Intensive Behavioural Intervention (EIBI), naturalistic developmental behavioural interventions (NDBI), developmental interventions, and parent-mediated interventions (PMI) (see the detailed list of recommended comprehensive early interventions in **Table 2** below). **Table** 10 describes a broader range of comprehensive interventions.

Early intervention should actively support and organise parental involvement in responses to children's needs, as jointly assessed, in all aspects of daily life.

In collaboration with parents, it is recommended to evaluate, on a regular basis, the effects of interventions on the child's development, as well as their acceptability for both the parents and the child.

It is also recommended to promote the inclusion of autistic infants and young children in mainstream group settings (early years provision and nursery school).

[13] See the CGP Haute Autorité de santé – Trouble du spectre de l'autisme – Signes d'alerte, repérage, diagnostic et évaluation chez l'enfant et l'adolescent "Autism Spectrum Disorder: Warning Signs, Identification, Diagnosis and Assessment in Children and Adolescents"

Table 2. Effectiveness of early interventions by functional domain in children under 6 years of age

Categories of interventions	Behavioural interventions	Developmental interventions	Naturalistic developmental behavioural interventions (NDBI)	Parent-mediated interventions	TEACCH
Common intervention methods included in the meta-analysis	based on ABA principles (EIBI)	PACT	ESDM JASPER	PACT JASPER	TEACCH
Domains of effectiveness					
Reduction in overall ASD symptoms (social communication deficits or restricted/repetitive behaviours)		→ **Grade C**		→ **Grade C**	
- Improvement in social communication	→ **Grade B**	→ **Grade B**	→ **Grade B**	→ **Grade B**	
- Reduction in repetitive behaviours					
- Improvement in expressive language	→ **Grade C**		→ **Grade C**		
- Improvement in receptive language	→ **grade C**				
- Improvement in adaptive behaviour	→ **Grade B**				
- Improvement in overall cognitive functioning	→ **Grade B**		→ **Grade C**	→ **Grade C**	→ **Grade C**
- Reduction in challenging behaviours					

→ **Intervention with significant effectiveness in the domain**

Blank cells indicate an absence of data or non-significant results.

ABA: Applied Behaviour Analysis; EIBI: Early Intensive Behavioural Intervention; ESDM: Early Start Denver Model; JASPER: Joint Attention, Symbolic Play, Engagement, and Regulation; PACT: Pediatric Autism Communication Therapy; TEACCH: Treatment and Education of Autistic and Related Communication-Handicapped Children

3.1.2. Interventions during childhood and adolescence

It is recommended to offer autistic children and adolescents a personalised intervention programme based on a graduated, coordinated and coherent pathway.

This programme should be tailored according to the results of a comprehensive assessment of the children's or adolescents' development and functioning in all domains (notably the adaptive, cognitive, emotional, communication, motor and sensory domains), in line with the list of recommended assessments, as well as their chronological age and interests.

The programme includes structured interventions combined with parent-mediated periods during daily life.

It is recommended to provide training for parents of autistic children and adolescents through psycho-education programmes, parenting skills training and/or therapeutic education in order to involve them actively in day-to-day support.

Peer support should be encouraged (for example, family peer support or peer support between children or adolescents).

It is recommended to ensure the consistency of interventions (educational, rehabilitative, pedagogical, clinical and social) by involving families, and to promote the generalisation of the children's or adolescents' skills throughout all of their living environments.

➔ **It is recommended to implement developmental and behavioural interventions:**

- prioritise interventions supported by the highest level of evidence of effectiveness, particularly for improving social communication, cognitive abilities and adaptive behaviour;
- offer autistic children and adolescents aged 6 to 19 years opportunities to participate in social skills training groups, which have proven to be effective in improving functioning in autistic children and adolescents without intellectual disability (Grade B);
- for autistic children aged 6 to 12 years, begin with cognitive behavioural therapy (CBT), which has shown significant effects on improving social communication (Grade C);
- for children aged 6 to 12 years, include parent-mediated behavioural interventions to reduce challenging behaviours (Grade B).

➔ **It is recommended to assess progress in each domain on a regular basis:**

- regardless of the intervention programme (**Table 3**), use standardised tools and/or scales for monitoring, in order to adjust interventions according to personalised assessments of needs;
- reassess the relevance of interventions in the absence of progress or in the event of symptom worsening, using a framework for identifying potential causes;
- carry out standardised functional assessments of the autistic child or adolescent at least annually, and more frequently during early childhood and at key transition stages;
- involve parents in these ongoing assessments in order to strengthen their role in any necessary adjustments.

3.1.3. Non-recommended interventions

It is incumbent upon the French National Authority for Health (HAS) to recommend only approaches supported by robust scientific data and to avoid methods that are not supported either by evidence or by consensus among experts appointed to develop a recommendation. However, some methods and

approaches assessed by HAS according to the principles set out in the methodological guide for clinical practice guidelines have either not been the subject of scientific studies or are supported by studies with insufficient quantitative and/or qualitative evidence, in contrast to the substantial body of data in the literature supporting other therapeutic approaches recommended by the HAS. Under these conditions, the following methods and approaches are not recommended:

- due to an absence of studies:
  - Doman-Delacato,
  - Feuerstein,
  - Padovan method or neurofunctional reorganisation;
  - facilitated communication and related methods, such as the Rapid Prompting Method;
  - Saccade®;
- due to an insufficient level of evidence:
  - primitive reflex integration;
  - Son-Rise®;
  - 3i;
  - neurofeedback;
  - psychoanalysis and other interventions based on psychoanalytic approaches;
  - Snoezelen;
- due to studies demonstrating a lack of effect:
  - “auditory integration” practices, including the Tomatis method (Grade B) [GPG 2012];
  - “packing.”

3.2. Interventions by functional domain

It is important to note that activities targeting a specific domain do not necessarily generalise to other domains. Professionals must therefore ensure that skills acquired in a specific context are generalised to other contexts [GPG 2012].

It is also recommended to involve families and other professionals working with the child/adolescent in order to facilitate this generalisation [GPG 2012].

3.2.1. Domain of independence in activities of daily living

For every child or young person with autism, the personalised plan must include functional objectives relating to independence in activities of daily living (dressing, personal hygiene, shopping, household chores, meals, transport, etc.), with a view to promoting the development of personal and social independence through specific learning during rehabilitation sessions (e.g. occupational therapy) or educational activities, followed by training in real-life situations at home, at school, at work, at leisure or holiday destinations, and in public places in general that the child or adolescent is likely to visit [GPG 2012].

For each of the domains considered below, it is essential to build on the interests and individual strengths of the autistic child or adolescent, as identified by professionals and families, in order to use them to foster learning and socialisation.

3.2.2. Communication interventions

The communication and language domain is a key area in which assessment by the intervention team is recommended for all autistic children and adolescents throughout their care and support pathway [GPG 2012].

At a minimum, this assessment includes monitoring the development [GPG 2012] of:

- non-verbal communication (joint attention, imitation, frequency of communication initiation, turn-taking, use of visual supports such as pictograms, etc.), even before the development of spoken language;
- the receptive and expressive components of the different dimensions of language: phonological, lexical, semantic, syntactic and pragmatic.

Language development should be monitored in spoken language (or sign language where appropriate) and, from the age of 6, in both spoken and written language, even where the development of spoken language is limited. It should also specify whether the child uses an alternative or augmentative communication system [GPG 2012].

The early provision, within any personalised plan, of Augmentative and Alternative Communication (AAC) tools is recommended, paying attention to ensuring the generalisation of their use throughout the child's/adolescent's different environments (home, school and/or specialised settings, and other social contexts) (Grade C). Parents need to be trained in the use of these tools in order to support this generalisation. When a child aged 6 years or older does not speak, written language teaching should not be excluded [GPG 2012].

Autistic children and adolescents, with or without intellectual development disorder, always exhibit communication difficulties, whether or not these are associated with language disorders.

All intervention plans must include a personalised communication component, regardless of the child's or adolescent's level of communication.

It is recommended that this component:

- be based on a comprehensive assessment of all aspects of the child's or adolescent's functioning, as well as environmental facilitators and barriers; any trained professional may contribute to the assessment of communicative functioning, in collaboration with parents;
- address both receptive and expressive communication, enabling the child or adolescent to understand, adapt to situations, and express agreement, refusal, opinions and consent;
- involve and support the family as a central stakeholder in the communication plan, which requires appropriate information and training for parents;
- be generalised throughout the individual's environments and to his or her communication partners;
- be based on the child's or adolescent's interests, drawing on the expertise of those around them;
- incorporate behavioural and developmental strategies to encourage communication initiatives by the autistic child or adolescent.

A speech and language therapy assessment of communication and language, including their pragmatic aspects, is recommended as part of both the diagnostic and functional assessment of the autistic child or adolescent.

In the presence of difficulties in communication, oral and written language, writing, mathematical cognition, orofacial myofunctional disorders, feeding and swallowing, or dysfunctional swallowing disorders, it is recommended to refer to speech and language therapy and associated disciplines (psychomotor therapy, psychology, occupational therapy).

As communication difficulties (expressive and receptive) are a major risk factor for challenging behaviours, speech and language assessment should be included in the functional assessment where such behaviours are present.

Augmentative and Alternative Communication (AAC)

A personalised communication plan may be implemented without preconditions for autistic children or adolescents, including for the introduction of Augmentative and Alternative Communication (AAC), which constitutes a core component of the overall intervention plan.

It is recommended to:

- individualise the AAC plan based on collaboration with families and all professionals, and on an evolving and coordinated functional assessment;
- use a range of tools and multimodal supports, which may be visual, gestural, with or without technology, prioritising those that promote the development of communication by the autistic child or adolescent;
- promote the involvement of communication partners, who play a key role in modelling, understanding, supporting and guiding the autistic child's or adolescent's communication while respecting their individual characteristics;
- adapt modelling to the sensory and social communication profile of the autistic child or adolescent;
- individualise and adjust communication approaches and tools to meet their current and future needs;
- where possible, use digital supports for Augmentative and Alternative Communication, such as tablets;
- ensure that the communication plan is supervised by a healthcare or support professional specifically trained in AAC, in partnership with the autistic child or adolescent, their family, and other professionals, in order to ensure consistency and generalisation throughout all living environments.

3.2.3. Interventions focused on social skills

The social interaction domain is a key area in which assessment by the intervention team is recommended, for all autistic children and adolescents throughout their care and support pathway [GPG 2012].

At a minimum, this functional assessment includes monitoring the development [GPG 2012] of:

- play skills (e.g. imitation, turn-taking, initiating, maintaining and ending play interactions);
- social skills and interactions in different situations (establishing and maintaining relationships with family members, peers, professionals, unfamiliar individuals and, subsequently, intimate relationships);
- social skills and interactions in different settings (initiating, maintaining and ending interactions at home, in childcare settings, at school, in healthcare and medico-social institutions, private practice, etc.).

It is recommended to:

- use social skills training groups, as early as possible and at least from the age of 6, in order to improve social and friendship skills in autistic children and adolescents;
- offer these interventions individually, in small groups or larger groups, depending on the profile of the autistic child or adolescent;
- implement them in routine activities, for example, during activities of daily living, sports, cultural or leisure activities, and in natural settings;
- use video modelling to facilitate the learning of adaptive behaviours and daily living skills, where appropriate for the autistic child or adolescent;
- develop training and protocols to integrate social skills groups into routine practice.

3.2.4. Interventions focused on sensory processing and motor skills

Sensory and motor assessment is a key prerequisite for intervention (see GPG 2018).

This assessment includes [GPG 2012]:

- screening for sensory impairments as for any child, with referral to specialist medical consultations where appropriate (ENT, ophthalmology);
- identification of preferred sensory modalities;
- identification of atypical responses to sensory experiences (tactile, proprioceptive, auditory, visual, gustatory or olfactory);
- monitoring the development of:
  - gross motor skills (general dynamic coordination, balance, posture);
  - fine motor skills and visuomotor coordination, including graphomotor skills;
  - muscle tone regulation;
  - body awareness (body knowledge, laterality and imitation abilities);
  - spatio-temporal organisation, ≈ praxis and gnosis.

Sensory processing

Taking sensory functioning into account is essential to identify the specific actions and adaptations required to promote sensory comfort for each autistic child or adolescent. Sensory assessments enable the identification not only of sensory processing difficulties in autistic children and adolescents but also their sensory strengths and preferences, which can be built upon as potential competencies.

➔ **Sensory assessment**

It is recommended to:

- carry out standardised sensory assessments, where possible, in a wide range of contexts, combining proxy assessment and direct assessment of the autistic child or adolescent, including situational observations;
- analyse sensory aspects in terms of hyper- and/or hyposensitivity, as well as sensory seeking or avoidance behaviours;
- regularly evaluate sensory-based strategies in order to measure their effects and make the necessary adjustments.

➔ **Sensory adaptations**

It is recommended to:

- enable autistic children or adolescents to access adapted spaces with graded sensory modifications, or spaces allowing them to withdraw without compromising their participation;
- reduce sources of visual and auditory distraction in shared environments;
- use sensory protection strategies where needed;
- incorporate the specific sensory profile of the autistic child or adolescent into the personalised plan so as to ensure its application in all environments and activities

Motor skills

It is recommended to:

- assess motor, praxis, postural, tone or gnosis-related difficulties that may negatively affect independence (hygiene, dressing, eating, leisure) and learning at school. A comprehensive assessment of motor functioning is required (HAS GPG 2018);
- offer psychomotor therapy and/or occupational therapy and/or physiotherapy and adapted physical activity, sometimes in combination, to support the development of motor and praxis skills;
- adapt the child's or adolescent's sensorimotor environment to avoid overstimulation or, conversely, provide appropriate levels of stimulation, particularly in terms of noise, light and textures.

➔ **Early signs (0–2 years)**

In the presence of very early atypical developmental signs (e.g. severe hypotonia, poor postural adjustment, reduced social engagement), it is recommended to offer standardised assessment and early intervention in psychomotor therapy, physiotherapy or ***ergotherapy***.

In the presence of clear neurological signs, atypical postures or delayed walking, a physiotherapy assessment and concurrent intervention should be prescribed.

➔ **From age 3 and during school years**

It is recommended to:

- include a physical or sporting recreational activity in the intervention programme;
- identify, through standardised assessment, difficulties in coordination or organisation of gross and fine motor skills;
- provide task-oriented motor interventions, individually and/or in groups, to support the development of motor skills relevant to independence, learning and socialisation;
- adapt the physical and social environment to meet specific motor needs;
- raise parental awareness regarding environmental adaptations within the home.

3.3. Environmental adaptations

The aim of contextual adaptations is to enable autistic children and adolescents to become active agents in their environment while making it predictable and accessible.

3.3.1. In the spatial environment

It is recommended to:

- take account of the specific support needs of each autistic child or adolescent and raise awareness among all professionals, including those in public settings;
- provide a structured environment adapted to the needs of autistic children and adolescents;
- ensure the sensory and physical comfort of the autistic child or adult to facilitate mobility, learning and activities;
- promote the modularity of living spaces to enable their adaptation to the learning and social participation needs of autistic children or adolescents;
- provide spaces in which autistic children or adolescents can relax;
- differentiate the functions of rooms by limiting the number of uses per space (e.g. clearly separating activity and living spaces, ideally with one space reserved for each function);
- provide, within the habitual environment, spaces enabling the modulation of sensory input for those who need it, while ensuring freedom of movement.

3.3.2. Temporal organisation

It is recommended to:

- personalise autistic children's and adolescents' daily routines, adjusting the pace and intensity of stimulation to prevent risks of over-occupation and/or under-occupation and fatigue;
- structure each autistic child or adolescent's individual timetable while maintaining sufficient flexibility to meet specific individual needs;
- clarify the duration and sequencing of activities.

3.3.3. In terms of information

It is recommended to:

- present information, instructions and schedules in a clear and adapted manner (notably through visual augmentative and alternative communication);
- involve the child or adolescent in planning their schedule and to inform them of changes in spaces, durations and sequences (before, during and after each stage);
- employ clear, concrete and unambiguous language adapted to the child's or adolescent's level of understanding and, where necessary, use visual supports (e.g. photo sequences, pictograms, objects, schedules) and avoid their premature withdrawal by gradually fading out their use;
- consistently use the child's or adolescent's habitual mode and tools of communication in all situations.

3.3.4. In terms of environmental adaptations

It is recommended to:

- raise awareness among all stakeholders, including those in public settings, regarding contextual adaptations that facilitate the participation of autistic children and adolescents;
- raise awareness among professionals in the built environment (architects, interior and outdoor designers, maintenance and safety personnel) of the specific characteristics of autistic children and adolescents (e.g. perceptions of time and space, sensory features);
- take the specific needs of autistic people into account in the definition of universal design and accessibility.

3.4. Technical aids

3.4.1. Remote activities: approaches and monitoring[14]

It is recommended that:

- in the absence of an appropriate alternative, and where relevant, professionals consider the use of remote care for autistic children or adolescents together with their family;
- the implementation of remote care be the result of a shared decision-making process between the autistic child or adolescent, their family and the professional, with the latter providing clear, fair and accessible information, and obtaining informed, formalised and documented consent from the parents or legal guardian;
- professionals delivering remote care to autistic children or adolescents assess the appropriateness of this approach, taking account of their specific needs as well as the material and technical conditions;
- professionals delivering remote care to autistic children or adolescents ensure that family caregivers are able to use the required technologies, and where necessary shall direct them towards, or provide, appropriate training or support.

It is recommended to:

- regularly assess the continued appropriateness of remote care, including any potential loss of opportunity;
- refrain from using remote care in certain situations where the child's or adolescent's condition requires in-person presence or where the material conditions are unsatisfactory;
- make sure that the implementation of remote care is adapted to the characteristics and needs of autistic children or adolescents, their parents, and the organisational and professional constraints of those delivering the intervention
- provide, on the one hand, a wide field of view for the camera in order to capture as many elements of the environment as possible, and on the other hand, guarantee the effective availability of the professional supporting the child or family during the session;[15]
- ensure that remote interventions follow the same guidelines as those for face-to-face interventions.

3.4.2. Tele-expertise

It is recommended to facilitate access to tele-expertise from autism specialists by improving the visibility of this provision at local and regional levels. This visibility notably enables primary care and medico-social professionals to benefit from expert input supporting early identification, referral and follow-up of autistic children and adolescents.

The provision of tele-expertise for autistic children and adolescents and their families should be specified and regularly updated throughout different regions nationwide.

[14] Haute Autorité de santé – Telehealth – Les bonnes pratiques (HAS – Remote care – Best practices)
[15] https://www.has-sante.fr/jcms/c_2971632/fr/teleconsultation-et-teleexpertise-guide-de-bonnes-pratiques

3.4.3. Digital tools

As applies to the general paediatric population, general recommendations regarding screen use apply to autistic children and adolescents. The aim is to promote positive, appropriate and balanced use of digital technologies.

Excessive screen use reported in the clinical history should not be considered a cause of social communication difficulties, nor should it delay the assessment of a possible autism spectrum condition in the child.

When used in a structured and adapted manner, digital technologies may serve as an enabler of learning for some autistic children and adolescents and a support for their interests.

It is recommended to systematically involve autistic children or adolescents, their families and professionals in the choice of digital tools.

It is recommended to provide information to facilitate their use and generalisation, taking account of the functional profile of the autistic child or adolescent concerned.

3.4.4. Research perspectives

Given the rapid development and market release of numerous technological tools – especially digital ones – often without scientific evaluation, a high level of vigilance is required prior to their use.

It is recommended to:

- facilitate access to transparent information on available digital tools, including evidence of their benefit, data protection considerations, and conditions of use and accessibility;
- promote close collaboration between healthcare professionals and industry, as such partnerships are essential to forge strong links between technical and clinical expertise;
- encourage the co-design of digital tools involving professionals, families and the individuals concerned;
- evaluate, through rigorous interventional research using appropriate methodology and protocols, the clinical and organisational value of digital tools for use with autistic children and adolescents.

4. Education, schooling and independence

Key messages

To ensure a comprehensive and coherent approach, the schooling of autistic children and adolescents requires close and sustained coordination and partnership between professionals providing support or care and the parents.

Professionals in schools and apprentice-training settings should receive training and support enabling them to adapt provision for autistic pupils and students.

Physical and sporting activities are an integral part of the intervention plan for autistic children and adolescents.

Participation in leisure activities, holidays and cultural life should be supported by the autistic child's or adolescent's broader network (family and professionals involved in support and in these activities), taking account of their interests.

The schooling of autistic children and adolescents falls within the framework of the provisions of the Law of 11 February 2005 on equal rights and opportunities, participation and citizenship for disabled people. These provisions aim to ensure the continuity of an educational pathway adapted to each pupil's skills and needs. They prioritise mainstream schooling close to the family home.

It is recommended to inform the autistic child or adolescent, but also to involve them and seek their participation in decisions concerning them in relation to their support,[16] both at key stages in the assessment, planning and revision of their personalised plan, and on an ongoing basis in the implementation of the planned interventions [GPG 2012].

It is recommended to take account of the children's or adolescents' level of understanding and maturity, as well as their preferences and interests [GPG 2012].

Listening to and informing the children or adolescents, while taking account of their views, should be ensured at all times, within and between all teams involved in supporting them and their families [GPG 2012].

4.1. Schooling

In this document, the term schooling refers to primary school, secondary school, further education, vocational training and university.

In accordance with the implementation of the Law of 11 February 2005, it is recommended to:

- ensure continuous schooling for autistic children and adolescents, without interruption, in order to support learning and the development of social skills;
- ensure, based on assessment of needs, access for autistic children and adolescents to all educational provision (including human support) offered within the French education system (cf. **Figure 1**);

[16] More generally, treatments, examinations and medical investigations that may be prescribed for children and adolescents with autism spectrum disorder must comply with the principles of obtaining and respecting patient consent, as set out in the French Public Health Code. The consent of minors must be systematically sought if they are able to express their wishes and participate in decision-making (Art. L. 1111-4 of the Public Health Code).

- adapt schooling to the individual pace of each autistic child or adolescent, in line with their development and learning;
- ensure regular communication between families and professionals regarding the educational and learning needs of the autistic child or adolescent within their schooling;
- prevent risks of school bullying;
- develop peer support roles (pupils or students) within schools, universities and vocational training settings in order to facilitate the participation and socialisation of autistic children or adolescents;
- promote schooling within the local environment, close to the family home, so that autistic children and adolescents can take part in extracurricular activities in their neighbourhood with their peers;
- facilitate the involvement of independent practitioners (paramedical professionals, psychologists, educators) within educational institutions;
- anticipate all educational transitions (changes of class, school or teacher, placements), from primary to secondary education and into further, vocational and higher education, by sharing relevant information (with parental consent), by preparing the pupil and by raising awareness among peers;
- prevent disruption to educational pathways by regularly reviewing the situation within the framework of the schooling monitoring team;
- ensure that alternatives are proposed by the schooling monitoring team, which should monitor their effective implementation, in the event of a breakdown in schooling;
- provide ongoing training for the educational community – especially teachers, educational psychologists and teaching assistants supporting pupils with disabilities – on child development and neurodevelopmental conditions, including autism, and raise awareness of disabilities among pupils in order to promote harmonious inclusive education;
- where autistic children or adolescents receive home education for medical reasons, provide appropriate support to meet their educational, learning and socialisation needs;
- provide adapted teaching and educational support for autistic children and adolescents throughout schooling and into vocational training and higher education;
- prevent disruption of educational pathways by anticipating and organising transitions at all ages, particularly into adulthood.

Schooling arrangements following a decision by the departmental disability centre

The personalised schooling plan (PPS), intended for pupils with disabilities, is developed with the departmental disability centre and is binding on the national education system.

The schooling of an autistic child or adolescent may require an official decision issued by the departmental disability centre, concerning: localised inclusive education units; human support: teaching assistants for pupils with special educational needs (SEN); institutions and services: autism-specific primary teaching units, autism-specific nursery teaching units, special education and home care services, specialised support and outreach service hubs; specialist educational institutes for children with disabilities, teaching units, and outreach teaching units (cf. **Figure 1**).

It is recommended to:

- ensure continuity of human support for the autistic child or adolescent by limiting the number of different SEN teaching assistants involved with the autistic child or adolescent. Where

changes of SEN teaching assistants occur, these should be clearly explained to the child or adolescent;
- support for schools, vocational training providers and universities with the identification of autistic pupils and assist them in obtaining diagnoses and, where appropriate, formal recognition of disability by the departmental disability centres.

4.2. Coordination and partnership on schooling for comprehensive and coherent support

It is recommended to:

- optimise resources and avoid overlaps and fragmentation in support pathways;
- develop regular collaboration between families, school staff and other professionals (medical, health and social care, independent practitioners) involved with autistic children or adolescents, in order to ensure continuity of support throughout the school day;
- provide for the organisation of school catering services and out-of-school care within schools;
- involve school health services (doctor and nurse);
- anticipate admissions to autism-specific nursery teaching units with the various professionals concerned (coordination and referral platform, early diagnostic teams and departmental disability centres) so that eligible children can be admitted in the year of their third birthday. It is recommended to structure and ensure the transparency of admissions to autism-specific nursery teaching units at territorial level;
- anticipate and secure, within autistic pupils' educational pathways, their transitions from autism-specific nursery teaching units, ***autism-specific primary teaching units*** and localised inclusive education units

4.3. Support and training for professionals in schools and vocational training settings

It is recommended to:

- strengthen and expand training programmes for professionals by including teaching on child development, the specific profiles of autistic children and adolescents, and learning strategies and pedagogical responses adapted to them;
- strengthen collaboration and coordination with independent practitioners (allied health professionals, psychologists, educators) and those in the health and social care sector working with autistic children or adolescents, within schools, universities and vocational training centres;
- support schools and vocational training institutions with the implementation of good practice guidelines on autism;
- develop both initial and ongoing training on autism for teachers, school leaders, inspectors, SEN teaching assistants, early years classroom assistants, and other staff working in schools (catering, extracurricular care, etc.);
- design joint, multi-professional and inter-institutional training programmes bringing together professionals from the national education system and the medico-social sector;
- provide support for SEN teaching assistants to help them adjust their practices, in practice and by drawing on medico-social resources (e.g. special education and home care service,

specialised support and outreach service hubs, school-based self-regulation units, etc.) and/or healthcare resources, and/or independent provision.

4.4. Physical activity and sport, leisure, and culture

4.4.1. Physical activity and sport

4.4.1.1. Adapted physical activity

It is recommended to:

- develop adapted physical activity programmes that take account of the functional limitations, interests, skills and specific needs of autistic children and adolescents, in collaboration with multidisciplinary teams;
- offer structured and organised adapted physical activity programmes tailored to the specific functioning of autistic children and adolescents, using appropriate communication tools to facilitate their understanding and participation;
- incorporate adapted physical activity programmes into the regular medical care of children and adolescents with autism and into the support provided by multidisciplinary teams;
- regularly evaluate adapted physical activity programmes in order to adjust them accordingly.

4.4.1.2. Physical activity and participation in sport

It is recommended to:

- systematically incorporate physical activity into the daily lives of autistic children and adolescents and their families in order to improve their physical health (e.g. weight or sleep issues) and overall quality of life;
- systematically include physical activity in intervention programmes delivered by educational, healthcare and medico-social institutions;
- inform and raise awareness among families of the importance of physical activity for their children, and provide them with resources and advice to facilitate access to these activities;
- include modules on the benefits of physical activity in psychoeducation programmes for parents and autistic children and adolescents;
- diversify the proposed physical activities, drawing on the strengths and interests of the autistic child or adolescent;
- support autistic children or adolescents and their families to encourage their involvement in physical and sporting activities;
- structure sporting environments and improve their accessibility, as with any other environment;
- regularly assess the benefits of physical activity on health, physical, behavioural and social aspects;
- support autistic children or adolescents in their sporting practices in order to foster enjoyment and develop relational and motor skills;
- regularly assess the benefits of physical activity on health, physical, behavioural and social aspects;
- develop specific training programmes for sports professionals so that they can provide appropriate and adapted support for autistic children or adolescents;
- provide training for healthcare, health and social care and independent professionals on the benefits of physical activity for autistic children and adolescents;

- use physical activity as a means of developing social skills and autonomy in autistic children and adolescents.

4.4.2. Access to leisure, holidays and culture

It is recommended to:

- provide material and human support to leisure, holiday and cultural organisations in order to enable the participation of autistic children and adolescents;
- provide leisure and holiday facilitators and cultural venue staff with the information and tools required to foster the effective participation of autistic children and adolescents;
- adapt the activities on offer to the profile of the autistic child or adolescent (communication, cognitive, motor, sensory and emotional);
- adapt leisure, holiday and cultural settings to the sensory and communication characteristics of autistic children or adolescents;
- use leisure, holiday and cultural activities to generalise the learning, communication and social participation of autistic children and adolescents;
- ensure consistency of support by developing local partnerships between educational, healthcare or medico-social settings and leisure, holiday and cultural venues;
- involve and support families so that they can best prepare for their child's participation in leisure and cultural activities;
- develop opportunities for exchange, awareness-raising and training on autism for leisure facilitators, holiday staff and cultural venue staff;
- develop adapted sessions and settings to enable the participation of autistic children and adolescents, and facilitate learning and generalisation (visual information, attention to sound and light, freedom of movement, quiet spaces).

In the absence of validated evidence for animal-assisted, music-based or art-based mediation techniques, these cannot be offered as therapies nor replace established interventions. However, they may be offered to autistic children or adolescents according to their interests and may contribute to fostering their participation.

5. Monitoring in primary and specialist care

Key messages

Autistic children and adolescents benefit from regular medical follow-up in primary care for prevention and early management, with particular vigilance for comorbidities frequently associated with autism (epilepsy, sleep, diet, digestion, etc.).

All healthcare professionals are made aware of autism, both in terms of approaches and adapting care to the specific needs of the children or adolescents concerned, and in ways of supporting their participation in care.

In the absence of any pharmacological or biomedical treatment specific to autism, any prescription – of psychotropic medication in particular – must be strictly regulated, preceded by prior information for families and an initial assessment, and accompanied by regular monitoring carried out in close coordination with the autistic child or adolescent, their family, and the professionals involved in their care.

Autistic infants, children and adolescents may also present physical or mental health conditions. These conditions may or may not be related to their autism. Their identification may be all the more difficult due to autism, particularly in terms of the perception and expression of symptoms and pain, and the acceptance of medical procedures.

Health monitoring takes account of conditions associated with the child's or adolescent's autism, including other neurodevelopmental disorders, epilepsy, psychiatric disorders (particularly during adolescence), instinctual functions (diet, digestion, sleep), and behaviour.

5.1. Physical and mental health monitoring

5.1.1. Foundations of physical and mental health monitoring

It is recommended to:

- implement health prevention measures through regular medical consultations;
- carry out, as for any child or adolescent, systematic medical follow-up using the personal child health record,[17] which enables the collection and sharing of information with other healthcare professionals and the family;
- ensure regular dental check-ups with a dentist and other specialists depending on associated conditions;
- seek specialist advice through tele-expertise where appropriate;
- determine priorities for intervention on co-occurring conditions associated with ASD according to their impact on the health and/or functioning of the autistic child or adolescent;
- carry out a specialist medical examination to define specific management arrangements in the case of an associated condition, particularly psychiatric or neurological;
- systematically offer a genetics consultation as part of the aetiological assessment, in line with current recommendations;

[17] Le carnet de santé de l'enfant – Ministère du Travail, de la Santé, des Solidarités et des Familles

- provide more frequent and regular medical monitoring in the case of prescribed medication, particularly psychotropics, in order to detect common adverse effects (e.g. extrapyramidal or metabolic signs, changes in mood, appetite or sleep);
- conduct, without delay, a physical examination to investigate a medical cause in the event of any unusual change in behaviour in the child or adolescent;
- repeat ENT and ophthalmological examinations, which may include a neurovisual assessment, in the event of warning signs relating to hearing or vision, even if they were previously performed at the time of initial diagnosis;
- follow the standard immunisation schedule for all infants, children and adolescents.

5.1.2. With a view to health prevention

It is recommended to:

- encourage and promote regular physical activity to limit the effects of sedentary behaviour;
- provide health education by promoting good nutritional practices (such as a varied and balanced diet) and daily hygiene (such as toothbrushing), in line with those recommended for any child or adolescent of the same age;
- develop knowledge of pain and its identification, especially as some manifestations of pain may be atypical and expressed through behaviours such as self- or hetero-aggression, or increased withdrawal;
- pay particular attention to specific pain, including gynaecological pain such as menstrual pain;
- increase the use of pain assessment scales that are standardised and adapted to the communication mode of the autistic child or adolescent, such as the pain assessment grid for individuals with intellectual disability (Grille d'évaluation de la douleur – déficience intellectuelle – GED-DI) or the simplified pain assessment scale for non-communicating individuals (Échelle simplifiée d'évaluation de la douleur chez les personnes dyscommunicantes – ESDDA);
- ensure appropriate therapeutic management of pain;
- ensure regular monitoring of sleep quality in order to detect and treat any sleep disorder;
- ensure regular monitoring of bowel function, with particular attention to the risk of constipation, in order to anticipate and manage potential complications;
- carry out a comprehensive assessment to adapt interventions in cases of food selectivity, intestinal conditions or restrictive diets, including an evaluation of dental health or any other factor increasing the risk of nutritional deficiency. Food selectivity, which is common in autistic children and adolescents, may pose a health risk and requires appropriate behavioural management and dietary support;
- analyse any unusual change in behaviour in order to identify possible causes such as: inadequacies in environmental adaptations or support; pain-related manifestations; physical health problems and/or psychiatric disorders. These observations lead to specific and coordinated responses involving both medical interventions and adjustments to support. (cf. **10**).

5.1.3. Focus: sleep disorders

It is recommended to screen systematically for sleep disorders, which are common in autism (particularly insomnia), by asking parents about the sleep habits of the autistic child or adolescent and, where necessary, using specific tools such as sleep questionnaires and sleep diaries.

It is recommended to provide families with information about behavioural approaches to managing sleep disorders that is adapted to the age and level of functioning of the autistic child or adolescent .

The initial management of sleep disorders is based on sleep hygiene, for both the autistic child or adolescent and their family. This includes establishing conditions conducive to healthy routines, creating a sensory environment adapted to the child's needs (lighting, temperature, noise, etc.), implementing regular bedtime routines, and using behavioural therapies.

It is important to explore the impact of sleep disorders in the autistic infant, child or adolescent on the family. As with any other intervention, it is important to take parents' observations into account, involve them in the strategies implemented, and consider long-term support for the entire family.

In cases of chronic sleep disorders, sudden onset or worsening of symptoms, it is recommended to investigate possible causes, including medical causes (e.g. pain), comorbidities (e.g. ADHD, restless legs syndrome, parasomnias, sleep apnoea, epilepsy), and, where necessary, to refer to a specialist sleep clinic.

It is recommended to consider treatment with melatonin (immediate- or prolonged-release) in cases where non-pharmacological interventions have only partial effectiveness and where sleep disorders have a significant impact on daily life, always in combination with non-pharmacological measures (cf. **Figure 2**) (see § **5.3.4** Prescription of melatonin).

It is recommended to regularly reassess the effectiveness, tolerance and relevance of melatonin treatment within the overall care context.

5.2. Preparation for consultations with healthcare professionals

5.2.1. Domains of awareness regarding the specific features of autism recommended for healthcare professionals

- Specific functional characteristics in autism:
- importance of taking the knowledge and observations of regular caregivers (parents or professionals) into consideration with regard to the specific patterns of functioning of autistic children or adolescents;
- adaptation of the reception of autistic children or adolescents: reducing waiting times; allowing for longer consultations; adapting environments; enabling gradual familiarisation with care, notably through "practice consultations" and "social stories";
- systematic identification of pain using standardised scales adapted to autism (e.g. pain assessment grid for individuals with intellectual disability (Grille d'évaluation de la douleur – déficience intellectuelle – GED-DI) or the simplified pain assessment scale for non-communicating individuals (Échelle simplifiée d'évaluation de la douleur chez les personnes dyscommunicantes – ESDDA));
- recourse, where necessary, to dedicated support services for healthcare provision to people with disabilities (such as Handiconsult, Handisoins, Handisanté, Handident) and to tools such as SantéBD or Handiconnect.

5.2.2. Recommended approach to ensure appropriate care and support the active participation of the autistic child or adolescent and their family

- Listening to and taking account of the family's observations; encouraging shared observation between the family and professionals to enable early identification of health problems, manifestations of pain and unusual behavioural changes, and emphasising the written traceability of shared information;

- involving the autistic child or adolescent and addressing them directly, and implementing gradual familiarisation with routine care, particularly medical and dental care (for example, practice consultations, educational workshops using medical equipment);
- using appropriate tools to prepare for care, such as augmentative and alternative communication (AAC) materials, and adapting the environment while taking account of autistic children's or adolescents' specific patterns of functioning, notably the sensory, communication, cognitive and motor aspects;
- basing this familiarisation on close partnership between the family and the professionals concerned;
- implementing educational actions to help autistic children or adolescents better understand, name and identify parts of their body, thereby facilitating the identification and localisation of pain.

5.2.3. Recommended implementation of care during consultations

- Taking account of the autistic child's or adolescent's ability to manage waiting when organising consultations;
- informing healthcare professionals, in advance of the consultation, about the need to adapt reception and care for the autistic child or adolescent;
- consulting the usual support network (family and professionals) to identify strategies that facilitate the delivery of care and allowing family members or professionals to be present during the consultation (ensuring the consent of the autistic child or adolescent);
- enabling the autistic child or adolescent to anticipate the delivery of care by preparing them and explaining the different stages using visual supports or other appropriate tools, and by progressively introducing medical equipment;
- managing pain and discomfort related to care by anticipating and adapting strategies according to the response patterns of autistic children or adolescents, using non-pharmacological approaches such as distraction and, where necessary, analgesic treatments (examples: topical anaesthetic dressing and equimolar mixture of oxygen and nitrous oxide – EMONO);
- when administering care during which the safety of the autistic child or adolescent is compromised, and when analgesic and/or sedative pharmacological options and habituation methods are not feasible (or cannot be implemented), considering the possibility of using secure temporary paediatric holding devices under their supervision and in the physical presence of a doctor. Their use is conditional upon prescription by a doctor and requires the informed consent of the autistic child or adolescent and their parents, including the reasons for and modalities of use.

5.3. Medications and other biomedical interventions for co-occurring conditions

Pharmacological treatments, and more generally any treatments, examinations and medical investigations that may be prescribed for autistic infants, children and adolescents must comply with the principles of obtaining and respecting patient consent, as set out in the French Public Health Code [GPG 2012].

Parents must receive clear and informed information about the expected benefits and possible risks of the various investigations, treatments or preventive actions (Article L.1111-2 of the Public Health Code). In accordance with their rights (Article L. 1111-4 of the Public Health Code), they may oppose

the prescription of medication for their child, provided that such refusal does not entail serious risks to the child's health (e.g. life-threatening situations, self-injury with risk of severe sequelae, etc.). For example, the admission of an autistic child or adolescent to an institution cannot be conditional upon the use of psychotropic medication. In cases of aggression endangering other persons within the institution, solutions must be sought with the child or adolescent and their family to ensure the protection of all [GPG 2012].

During adolescence, the question of the appropriateness of prescribing contraceptives should be considered [GPG 2012].

5.3.1. General principles for pharmacological interventions in autism spectrum disorder

In the absence, to date, of any curative pharmacological treatment for autism, medication prescriptions (such as for psychotropic drugs) are symptomatic, for example to reduce the severity of behavioural difficulties or to manage co-occurring conditions such as epilepsy,[18] or ADHD.[19]

It is recommended to:

- use pharmacological prescriptions within a multimodal approach combining them with behavioural interventions and psychosocial support;
- favour monotherapy when prescribing psychotropic medication in order to limit drug interactions
- carry out a thorough prior assessment to justify any pharmacological prescription;
- take co-occurring conditions into account when prescribing.

5.3.2. Information, monitoring and involvement of autistic children or adolescents, their families and the professionals supporting them

It is recommended to:

- provide autistic children or adolescents and their families with information adapted to their needs on the objectives of pharmacological treatment, the risks of adverse effects and the hygiene and dietary rules to be followed to reduce these risks;
- obtain parental consent (legal guardians or tutor where applicable) and seek the informed consent of autistic children and adolescents;
- ensure continuous collaboration between autistic children or adolescents, their families and the professionals supporting them, in order to incorporate their feedback and the collection of objective data into treatment monitoring, particularly to promote adherence;
- adapt treatments based on the assessment of needs and the views of autistic children or adolescents and their family;
- provide the autistic child or adolescent and their family with precise information on the hygiene and dietary rules to be followed when taking psychotropic medication;
- systematise the monitoring of treatment efficacy and tolerability within shared protocols involving all stakeholders and families.

[18] Haute Autorité de santé – Épilepsies : prise en charge des enfants et des adultes [Epilepsies: management of children and adults]

[19] https://www.has-sante.fr/jcms/p_3302482/fr/trouble-du-neurodeveloppement/tdah-diagnostic-et-interventions-therapeutiques-aupres-des-enfants-et-adolescents

5.3.3. Prescription and monitoring of psychotropic treatments

Practice surveys show that a high proportion of autistic children or adolescents receive psychotropic treatments, even though most of the molecules used have not been granted marketing authorisation (MA) for this indication or for this population [GPG 2012].

Under these circumstances, any prescription must be cautious, judicious and based on objective data enabling the prescriber to regularly assess the benefit–risk balance for each patient [GPG 2012].

Other than under exceptional emergency situations, it is recommended that the initial prescription of psychotropic medication be decided by a child and adolescent psychiatrist, psychiatrist, paediatrician, paediatric neurologist or neurologist. The general practitioner is informed of the prescription and of its modalities for renewal and monitoring [GPG 2012].

As a general principle, psychotropic medications should be prescribed only exceptionally and on a temporary basis in autistic children and adolescents. Regular reassessment of the indication (every six months or earlier depending on the duration recommended by the MA) should be proposed, including the implementation of a treatment break [GPG 2012].

Lack of efficacy or poor tolerance should lead to discontinuation [GPG 2012].

It is recommended:

- as a first-line approach and outside of urgent somatic situations, to prioritise recommended non-pharmacological, psychosocial and behavioural interventions before considering the prescription of psychotropic treatment;
- in the event of any acute change in behaviour, systematically investigate an underlying medical or environmental cause, supported by a functional analysis, before prescribing psychotropic treatment (cf. **Figure 3**);
- before initiating any psychotropic treatment, to carry out a full physical assessment including paraclinical investigations adapted to the clinical condition of the autistic child or adolescent and to the monitoring requirements of the prescribed treatments;
- to initiate psychotropic treatments at low doses with gradual titration to the effective dose in order to monitor tolerance and efficacy;
- to carry out regular evaluation, at each prescription renewal, of the response to psychotropic treatment, including verification of the achievement of the therapeutic objectives set, adjustment of dosage if necessary, and monitoring of clinical and paraclinical tolerance and adverse effects;
- to regularly reassess the indication for psychotropic treatment in order to avoid unjustified prolonged use, in particular through treatment breaks or deprescribing protocols;
- to refrain from multiplying psychotropic prescriptions, ensuring rigorous coordination between the various prescribing physicians;
- to avoid anticipatory prescriptions of psychotropic medication.

5.3.4. Melatonin prescription

It is recommended:

- in the case of significant and chronic sleep disorders, to prescribe melatonin in addition to educational, behavioural and hygiene and dietary measures (cf. **Figure 2**);
- to adapt the pharmaceutical formulation of melatonin to individual needs;

- to standardise and secure the use of melatonin through clear initiation regimens and maximum dose schedules;
- in cases of sleep disorders improved by melatonin, to maintain melatonin prescription beyond the age of 18 if chronic sleep disorders persist.

5.3.5. Prescription of diets

Dietary regimens and food supplements have no specific indication in the treatment of autism.

Exclusion diets (for example, gluten-free or casein-free) are reserved for strict medical prescription following confirmation of a diagnosis of food intolerance or a specific gastrointestinal condition (for example, coeliac disease). These diets require regular medical monitoring.

6. Adolescence and transition to adulthood

Key messages

The frequency of psychiatric comorbidities in autistic individuals from adolescence onwards requires increased vigilance from professionals, in order to enable the earliest possible specialist intervention.

Continuity of care and appropriate interventions is ensured up to entry into adult life. By involving the autistic adolescent or young adult and their family, professionals ensure coordinated transfer of information and the establishment of necessary onward arrangements.

Initial diagnosis of autism during adolescence or adulthood is of critical importance in ensuring appropriate care and support. It is therefore essential to prevent any risk of overdiagnosis or underdiagnosis by relying on a rigorous clinical approach that is both multidimensional and multidisciplinary.

6.1. Life course: continuity of care and appropriate interventions

It is recommended:

- to anticipate transition to adult life from the age of 14-15 years;
- to develop care and support pathways for autistic adolescents and young adults within a framework of self-determination and to support transitions in a coherent manner;
- to mobilise, throughout the school year, medico-social and community-based teams and schooling monitoring teams to undertake practical preparations for educational and vocational transitions;
- in order to ensure fluidity and coherence of the care pathway and in education (specialist or mainstream) from childhood or adolescence to adulthood, that the team responsible for the child's or adolescent's follow-up should provide the teams responsible for ongoing follow-up with a written report on this pathway, with the agreement of the autistic child or adolescent;
- to ensure continuity of care and specialised educational follow-up during transitions and over time, notably the continued use of augmentative and alternative communication modalities;
- to systematically establish early and coordinated collaboration with adult healthcare services at the point of transition from adolescence to young adulthood (16–18 years).

6.2. Risks of psychiatric disorders: prevention and monitoring

It is recommended to:

- identify, during adolescence in autistic individuals, warning signs of depression and anxiety, which are more frequent in autism, in order to facilitate referral to a child and adolescent psychiatrist or a general psychiatrist;
- develop a practical guide for identifying mental health problems in autistic adolescents and young adults for primary care professionals, in order to facilitate detection;
- be attentive to the increased risks of stigmatisation and bullying affecting autistic children or adolescents;
- directly explore the risk of suicidal ideation or suicide plans with autistic children or adolescents, particularly those with co-occurring psychiatric conditions, gender incongruence and/or a history of bullying, or physical or sexual abuse.

6.3. Late diagnosis

It is recommended to facilitate access to a diagnosis of autism spectrum disorder at any age, as it enables access to appropriate interventions, specific rights, and contributes to better self-understanding for the individual concerned as well as improved understanding by those around them.

For an adolescent or young adult in whom autism is suspected, it is recommended, in conjunction with their family, to discuss the value of a multidimensional diagnostic assessment.

It is recommended to develop screening and diagnostic tools for autism spectrum disorder in adolescents and young adults with suspected autism, whether or not an associated intellectual disability has already been identified.

As initial diagnosis of autism in adolescence or young adulthood is of critical importance in ensuring appropriate care and support, it is essential to prevent any risk of overdiagnosis or underdiagnosis by adopting a rigorous clinical approach that is both multidimensional and multidisciplinary.

7. Autistic individuals with intensive needs – profound autism[20]

Key message

Individuals with profound autism have specific needs that are intensive, continuous and general in terms of support.

7.1. Definition of the notion of autistic individuals with intensive needs – profound autism

Autistic children and adolescents with intensive support needs – profound autism – are those who require intensive and continuous support 24 hours a day, 365 days a year.

Intensive support needs – profound autism – should not be confused with severe behavioural disorders (or challenging behaviours). The intensity of needs implies that they must be anticipated but does not call into question either the diagnosis of autism, the need for early interventions, or the need for social participation, access to education and access to all medico-social or healthcare services.

The intensity of support needs in these autistic children and adolescents becomes apparent over time and not at the initial diagnosis, particularly when the child or adolescent does not respond sufficiently well to early interventions implemented from the time of initial diagnosis and/or shows developmental regression. The difficulties are likely to worsen in the absence of appropriate interventions. Autism with intensive support needs – profound autism – has a major impact in terms of quality of life and psychosocial consequences for the child and their environment (family and caregivers).

Autistic children and adolescents with intensive support needs – profound autism – present the following characteristics:

- severe intellectual developmental disorder, resulting in significant learning difficulties and requiring adapted educational approaches;
- significant limitations in adaptive functioning, requiring constant supervision to meet safety needs and activities of daily living for the individual and their environment;
- absence or major limitation of receptive and expressive communication, preventing the individual from effectively understanding their environment and expectations, and from effectively expressing their requests and needs.

It is recommended to:

- define the intensity of needs in order to determine the level of support required;
- anticipate the progression of these needs, which are likely to increase with age;
- plan enhanced support throughout the person's life;
- implement regular medical follow-up and continuous, sustained medico-social and social support.

[20] *Profound autism*, see Lord C, Charman T, Havdahl A, Carbone P, Anagnostou E, Boyd B, et al. The Lancet Commission on the future of care and clinical research in autism. The Lancet 2022; 399: 271-334.

7.2. Principles of support for autistic individuals with intensive needs – profound autism

It is recommended to:

- strengthen structuring of time, augmentative and alternative communication, and environmental adaptations, particularly sensory adaptations;
- increase staffing levels and material resources to enable the continuation of existing support (medico-social, healthcare and educational) in order to avoid breaks in care pathways;
- focus on maintaining acquired skills and developing autonomy in daily living (sleeping, eating, washing, dressing, moving around, etc.);
- build on the interests and routines of autistic children or adolescents to engage them in socially valued activities;
- ensure the safety of autistic children or adolescents in all environments;
- offer autistic children or adolescents and their families activities within the most inclusive setting possible;
- enhance training and supervision for professionals;
- strengthen human support resources, including respite, support, guidance and psychoeducation, in order to take account of parents' and siblings' needs;
- improve preparation for the transition to adulthood, in coordination with the family and the various adult support services;
- identify and assess frequently associated conditions in children and adolescents with intensive support needs – profound autism – which may mask one another;
- identify, through regular monitoring, somatic comorbidities (in particular neurological conditions such as epilepsy) and psychiatric comorbidities, which are more frequent but also more difficult to identify, as autistic children or adolescents with intensive support needs –profound autism – rarely express their pain explicitly;
- make use, where necessary, of solutions developed in the field of profound and multiple disabilities, and to apply them to autistic children and adolescents with intensive support needs (cf. HAS guidelines on profound and multiple disabilities).

7.3. Points of vigilance for public health actions

It is recommended to:

- precisely identify individuals with autism with intensive support needs – profound autism – in France in order to better plan responses to their needs;
- develop national information and training campaigns on autism with intensive support needs – profound autism – so that its impact on the daily lives of individuals concerned and their families, on professional practices, and on the development of specialised services is better recognised;
- develop clinical research programmes and research in the humanities and social sciences relating to this population.

8. Support for relational, emotional and sexual life

Key message

Relational, emotional and sexual education[21,22] should be adapted to the specific characteristics of each autistic adolescent or young adult.

8.1. For autistic children and adolescents:

It is recommended to:

- provide them with information adapted to their developmental age, their level of understanding and their usual modes of communication, in order to support their expression – verbal and non-verbal – concerning bodily changes related to puberty. The information provided should be progressive, concrete and supported, where necessary, by visual materials, pictograms or videos;
- teach them how to ask for help on these topics, by informing them of the existence of several possible contacts: members of their family, support professionals, staff from family planning services or specialised resource centres (e.g. Intimagir);
- adapt existing educational materials to address the main themes relating to bodily and psycho-affective development within relational, emotional and sexual education (in particular puberty, menstruation, masturbation, emotional orientation and consent), taking account of the level of understanding and the sensory and cognitive characteristics of the autistic child or adolescent.

In cases of gender incongruence or gender dysphoria in a person with autism spectrum disorder, a cautious approach is required both in the diagnostic process and in the provision of support and care. The complexity of these situations requires close collaboration between autism specialists and experts in gender incongruence/dysphoria, in order to ensure a response adapted to the specific needs of the individuals concerned. It is reiterated that there is no robust evidence regarding an association between autism and gender incongruence/dysphoria.

8.2. By the professionals supporting them, in collaboration with families

It is recommended to:

- integrate, on a regular and anticipatory basis, sessions on relational, emotional and sexual education into support programmes before puberty, and then throughout adolescence and during the transition to adulthood. These sessions are aligned with national education frameworks while being adapted;
- adapt relational, emotional and sexual education content and tools to the specific profiles of autistic children or adolescents, taking account of their sensory, cognitive and communication characteristics (e.g. social stories, social comics or visual digital tools, concrete objects);

[21] A distinction is made between relational, emotional and sexual education, and

[22] intimate, emotional and sexual life. Intimate, emotional and sexual life is a component of human dignity and one of the fundamental freedoms.

- place emphasis within these relational, emotional and sexual education tools on the concepts of respect for self and others and explicit consent;
- raise awareness and provide training for all professionals working in social and medico-social facilities or services, educational settings or healthcare institutions, as well as families, regarding the importance of relational, emotional and sexual education, including the identification of signs of vulnerability, maltreatment or abuse;
- offer autistic individuals who are victims of sexual violence adapted multidisciplinary support, ensuring safe reception, respectful medical care and facilitated access to legal procedures, with specific psychological support;
- incorporate into family support the educational approach to their child's relational, emotional and sexual life.

9. Specific case of support within child protection services

Key messages

Training of child protection professionals in autism is essential for the prevention of unjustified referrals or safeguarding concerns, and for the provision of adapted support for the autistic children or adolescents concerned.

Complementarity between the different fields of intervention (child protection, justice, education, medico-social sector, etc.) is ensured through networked working methods involving stakeholders as well as inter-institutional coordination meetings.

9.1. Avoiding diagnostic errors and promoting an appropriate pathway

It is recommended to distinguish between signs of autism and signs of proven maltreatment, in order to avoid unjustified referrals or safeguarding concerns..

It is recommended to make the official list of medical experts in autism spectrum disorder, attention deficit hyperactivity disorder and specific learning disorders available for use by the services responsible for receiving and assessing safeguarding concerns (cellules de recueil des informations préoccupantes) and judges.

It is recommended to promote close support for families whose autistic child or adolescent is subject to a protection measure, in order to enable appropriate interventions.

For any autistic child or adolescent admitted to a child protection service, it is recommended that professionals ensure the provision of appropriate support and follow-up, and collaborate with specialist and primary care services.

Prior to any placement decision concerning autistic children or adolescents, it is recommended that child protection services verify that the placement conditions meet the individual's specific characteristics and provide access to interventions that meet their needs.

It is recommended to plan a support pathway for the autistic child or adolescent, including an initial assessment of their needs and the development of an individualised support plan.

9.2. Training and support for child protection professionals and foster families

It is recommended that child protection institutions and services comply with the HAS good practice guidelines (GPG) as a prerequisite for any placement..

It is recommended to train child protection professionals to develop a better understanding of the development of autistic children or adolescents by generalising an initial training programme throughout the child protection sector.

It is recommended to develop a disability resource team within child protection services that is trained in evidence-based autism practices and able to intervene in institutions, at home, in residential care or in foster families.

It is recommended to provide specialist training for foster families, supplemented by parental guidance and regular educational supervision, in accordance with current scientific knowledge.

It is recommended to promote collaboration with parents and/or foster families by involving them in diagnostic and follow-up consultations, in order to implement appropriate guidance within the framework of the protection measure.

9.3. Adaptation of environments

It is recommended:

- to guarantee an appropriate educational environment for every autistic child or adolescent, regardless of their care arrangements (within the birth family, the foster family or in a residential care setting);
- to anticipate and prepare for the removal of an autistic child or adolescent from the family home, and for changes in their placement, in association with all medico-social, social, educational, healthcare and, where necessary, emergency services;
- to systematically support school professionals during a change of school placement so that they are able to provide an appropriate welcome for the autistic child or adolescent. This work is based on cooperation between child protection services and all other stakeholders: the national education system, the medico-social sector, healthcare services, and youth judicial protection services;
- to ensure that changes in family or institutional living environments for autistic children and adolescents do not interfere with the quality of the interventions required;
- for autistic children or adolescents already supported within social and medico-social facilities or services, to work in partnership with child protection services and foster families in order to ensure consistency in support;
- to guarantee that interventions for autistic children or adolescents placed under the responsibility of child protection services comply with current scientific knowledge and, for this purpose, to train professionals in all child protection structures. Foster families must therefore have access to parental guidance, caregiver training and the use of communication tools;
- to develop the partnership between the justice system, child protection, medico-social services, the education system and healthcare services:
- to maintain and preserve the implementation of recommendations in accordance with Action Sheet 38 of the Autism Plan-2017 and the proposals of the 2015 report of the Defender of Rights.

10. Prevention and responses to challenging behaviours

Key message

The management of challenging behaviours displayed by certain autistic children or adolescents requires a medical assessment, a functional analysis and behavioural interventions.

For the prevention and management of challenging behaviours, refer to the professional good practice guideline "Les comportements-problèmes" ["Challenging Behaviours"] (sections 1 – prevention strategies, 2 – intervention strategies and 3 – calm withdrawal and soothing spaces) (HAS/former ANESM), [23] in addition to the guide entitled "Qualité de vie : handicap, les problèmes somatiques et les phénomènes douloureux" ["Quality of Life: Disability, Somatic Conditions and Painful Phenomena"].[24]

10.1. Challenging behaviours: prevention, support and management

For every autistic child/adolescent, every personalised plan, whatever the setting in which it is implemented, must include actions designed to prevent and, where appropriate, reduce or resolve challenging behaviours [GPG 2012].

Among the interventions proposed to prevent the occurrence of challenging behaviours, the following are recommended [GPG 2012]:

- implementation of a consistent augmentative and alternative communication system across the different living environments of the child/adolescent when they have little or no spoken language (Grade C);
- adaptation of the environment (e.g. spatial and temporal structuring, sound and lighting environment, etc.);
- anticipation of situations that usually trigger challenging behaviours.

Not every behavioural characteristic systematically requires a specific intervention designed to reduce it [GPG 2012].

In the event of behavioural difficulties, it is recommended, in collaboration with the parents and the child's/adolescent's usual support network, to investigate [GPG 2012]:

- somatic comorbidities or manifestations of pain, using an observational pain assessment scale;
- the contexts in which challenging behaviours occur and their function, in order to determine, through functional assessment, the factors triggering, maintaining or reinforcing these behaviours.

[23] https://www.has-sante.fr/jcms/c_2834964/fr/les-comportements-problemes-au-sein-des-etablissements-et-services-accueillant-des-enfants-et-adultes-handicapes
https://www.has-sante.fr/jcms/c_2833763/fr/les-espaces-de-calme-retrait-et-d-apaisement

[24] "Qualité de vie : handicap, les problèmes somatiques et les phénomènes douloureux" Haute Autorité de Santé - Qualité de vie : handicap, les problèmes somatiques et les phénomènes douloureux

In the event of behavioural difficulties requiring a specific educational intervention or pharmacological treatment, these may be initiated in parallel with medical investigations for somatic causes, but must not replace them [GPG 2012].

In the event of challenging behaviours (significant, intense, repeated or persistent disturbance, or behaviour presenting danger to the child/adolescent or to their environment and compromising learning, adaptation and social inclusion), it is recommended to promote the learning of adaptive behaviours through appropriate psychological or educational techniques [GPG 2012].

Among the interventions proposed to encourage the learning of adaptive behaviours with a view to reducing the frequency or intensity of challenging behaviours, the following are recommended [GPG 2012]:

- behavioural psychoeducational techniques (Grade C);
- any intervention achieving such learning through positive reinforcement of the child/adolescent;
- certain pharmacological treatments (cf. § 4.4), in association with the non-pharmacological strategies mentioned above.

In the event of self-injurious behaviour, the use of specific protective equipment may be considered (such as a helmet) [GPG 2012].

10.2. Implementation of resolution strategies for challenging behaviours and crises in order to avoid breakdowns in support

The reduction of challenging behaviours, beyond its potential impact in terms of improving the individual's quality of life, enables the avoidance or at least the limitation of breakdowns in support and subsequent inappropriate care pathways [GPG 2012].

It is recommended that professionals responsible for the follow-up of the child/adolescent [GPG 2012]:

- identify and assess the problematic nature of behaviours through consultation between parents, their child and professionals, using specific tools. Challenging behaviours require broader reflection on the support provided and the resulting way of life for the individual. This requires observation, analysis of repeated situations leading to the behaviour, vigilance, knowledge of alternative situations, and continuity within the educational and/or school team;
- bring together observations from the family and the various professionals involved (cf. crisis);
- identify this issue within the institutional project and implement resources to enable its management;
- develop tools facilitating the identification and analysis of these challenging behaviours (frequency, circumstances, events or interactions favouring or, conversely, stopping the behaviour; analysis of solutions already tested and those leading to positive outcomes), from their onset, and establish specific alert procedures;
- disseminate internally the factors covered by identification procedures: personal, psychological and somatic factors, family and institutional interactional factors, contextual factors;
- train professionals to manage these situations;
- prepare, where hospitalisation is unavoidable, the conditions of admission with the receiving hospital, as well as the conditions for return to the child's/adolescent's usual living environment.

11. Role and training of professionals

Key messages

The clinical practice guidelines on autism apply to all initial and ongoing training programmes, whatever the professions concerned.

When conducted in compliance with good practice guidelines, the supervision of professional practice is a key driver of continuing professional development, promoting both the appropriation and the concrete implementation of these recommendations in everyday professional practice.

Professionals contribute to the quality of care pathways for autistic children and adolescents through a multidisciplinary and coordinated approach.

For care pathways and coordination, refer to the professional clinical practice guideline entitled "Pratiques de coopération et de coordination du parcours de la personne en situation de handicap" [Cooperation and Coordination Practices in the Care Pathway of Persons with Disabilitites].[25.]

11.1. Training and supervision of professionals

The need to update professionals' knowledge in the field of autism applies to all professionals working with autistic children or adolescents, regardless of their mode of practice or sector of activity, but also to professionals working within departmental disability centres, although the objectives and content of the training provided must be adapted to the responsibilities of each professional. This effort must begin during initial training and continue throughout professional life [GPG 2012].

It is recommended that all members of the relevant teams, including managerial staff, benefit from these training plans, in order to promote consistency of support, facilitate and support any necessary dynamics of change within the whole team, and avoid the isolated development of practices that could disrupt the children and adolescents receiving support [GPG 2012].

Such training should be offered regularly and supported by the organisation, and subsequently evaluated with regard to its contribution within institutions or services (improvement in functioning, contribution to resolving potential difficulties, and the updating, where appropriate, of educational and therapeutic techniques, etc.) [GPG 2012].

It is recommended to:

- develop the expertise of all professionals involved in interventions;
- encourage the sharing of practices and territorial collaborations in order to improve continuity across care pathways;
- promote the training of all professionals involved in interventions;
- provide autism-specific training for primary care professionals (particularly general practitioners, paediatricians, doctors and other health professionals working in PMI services and nurseries, and professionals within follow-up networks for vulnerable newborn infants);

[25] Haute Autorité de santé – Pratiques de coopération et de coordination du parcours de la personne en situation de handicap

- improve training for medical and non-medical professionals in the early identification of developmental disorders;
- incorporate scientifically validated knowledge on autism into the initial and ongoing training of medical, paramedical, educational, social care professionals and psychologists;
- develop transdisciplinary and multiprofessional training programmes;
- incorporate the good practice guidelines on autism into the initial and ongoing training of all professions involved in interventions for autistic children or adolescents and their families;
- establish a common core of up-to-date knowledge for all professionals involved;
- develop practical simulation-based training for the concrete implementation of recommended interventions;
- enable families with recognised experiential expertise to participate in the training programmes;
- provide specific training for managerial professionals (heads of institutions or services, heads of departments, etc.) regarding the impacts of supporting autistic children and adolescents on recruitment, team management and departmental organisation;
- implement individual and team supervision, in accordance with clinical practice guidelines, on a regular basis (according to the needs of professionals and autistic children or adolescents), in addition to training, as a key tool for improving practice.

11.2. Role of professionals in care pathways and their coordination

Partnership with families

It is recommended to:

- develop parental guidance programmes at every stage of the pathway (identification, diagnosis and interventions, transition to adulthood);
- incorporate the family's needs into the overall assessment of the child's needs, in order to ensure comprehensive support;
- provide families with clear and regular information regarding their rights, available resources and possible interventions.

The personalised plan

It is recommended to ensure, on a daily basis, consistency in professional approaches between the professionals involved (importance of stable reference points for individuals, consistency in the words used to designate objects, consistency in routines and modes of functioning, as well as reference to the institutional/service project, etc.) [GPG 2012].

It is recommended to organise the coherence and complementarity of the personalised intervention plan implemented by professionals working in a coordinated manner with the child/adolescent, regardless of their sector of activity, with the life project of the child/adolescent and their parents and, where the child/adolescent is recognised as disabled by the departmental disability centre, with the personalised compensation plan[26] and the personalised schooling plan[27] [GPG 2012].

[26] Articles L. 114-1-1, L. 146-8 and R. 146-29 French Code for social action and families.
[27] Articles L. 112-2 and D. 351-5 of the French Education Code.

Organisational arrangements for transdisciplinary work

The services of a wide range of professionals, institutions and agencies are required in order to adapt the support and follow-up to the specific needs of autistic children and adolescents, who form a heterogeneous population [GPG 2012].

However, the involvement of multiple professionals and settings must not lead to fragmented interventions. The key issue is to bring together the professionals required to work in a coordinated manner with the child/adolescent, regardless of their sector of activity, from the outset of the process of assessing the child's/adolescent's needs and resources, in order to ensure the complementarity and coherence of interventions, the necessary adjustments to these interventions, and thereby secure the care pathways while maintaining sufficient fluidity and flexibility [GPG 2012].

It is recommended to implement a transdisciplinary approach to assessment as well as to the implementation and coordination of educational and therapeutic interventions, and to define in advance the operational rules governing this transdisciplinary work between professionals from different specialities within the same team or even from different institutions [GPG 2012].

These operational rules must be known and shared by all those involved with the child/adolescent [GPG 2012].

These elements must also appear in the personalised compensation plan and, where appropriate, in the personalised schooling plan [GPG 2012].

Organisation and coordination of pathways

It is recommended to:

- disseminate within each territory information regarding the graduated pathways for identification, diagnosis and support for neurodevelopmental disorders (coordination and referral platforms for neurodevelopmental disorders, early childhood health and social care centres, special education and home care services and other social and medico-social facilities, autism resource centres, centres of excellence and specialist centres for language and learning disorders, Child and adolescent mental health centre, specialised third-line neuropaediatric, child psychiatry or physical and rehabilitation medicine consultations);
- encourage local associations of healthcare professionals, in line with their healthcare pathway organisation remit, to include pathways for autistic infants, children and adolescents among their priorities;
- encourage territorial stakeholders to improve the fluidity of pathways for autistic children and adolescents by formalising their modes of collaboration (coordination and referral platform, local associations of healthcare professionals, independent professionals, follow-up networks for vulnerable newborn infants, the national education system, social and medico-social facilities or services, healthcare services, early childhood settings, maternal and child protection services);
- ensure effective and graduated coordination between stakeholders involved in identification, diagnosis and intervention pathways;
- identify a pathway coordinator responsible for monitoring and coordinating key stages. Pathway coordination must be carried out by professionals competent in this field and trained in autism;
- formalise multiprofessional discussion times for autistic children or adolescents followed up exclusively in independent practice (with the identification of a coordinator) in order to monitor the intervention plan and structure collaborations (cf. HAS recommendation on multidisciplinary consultation meetings);

- build the pathway together with the family and the autistic child or adolescent, rather than merely informing them after decisions have been taken;
- update the administrative and regulatory frameworks governing authorisations granted to medico-social institutions and services, in order to adapt them to the specificities of autistic people.

The coordination function

Within every institution, service or service provision arrangement, it is recommended to designate a professional or professional pair responsible for coordinating interventions in relation to the implementation of the child's/adolescent's project [GPG 2012].

This coordination function may also be carried out by an independent practitioner.

The aim of this recommendation is to assist parents with the coordination of interventions concerning their child and to avoid leaving parents isolated and solely responsible for a coordinating role they may not have chosen to undertake. However, some parents may refuse this assistance and personally wish to coordinate the interventions carried out in mainstream settings [GPG 2012].

The professional or professional pair appointed to carry out this coordination function for the personalised intervention plan and to oversee its implementation and monitoring [GPG 2012]:

- acts as the main point of contact for the various stakeholders and, in this capacity, communicates with the child/adolescent, the family, team members and any other person concerned;
- ensures the smooth running of the different phases involved in developing and implementing the personalised plan and the coherence of interventions;
- ensures, as a priority, the protection of the child's/adolescent's rights and interests.

It is recommended that independent practitioners liaise with the other professionals supporting the child/adolescent concurrently with their intervention (and vice versa) [GPG 2012].

Information-sharing arrangements

A coherent personalised plan encompassing various forms of intervention cannot function without effective coordination and continuous interactions between professionals within the framework of flexible and transversal communication both internally and externally [GPG 2012].

It is recommended to appoint a designated individual pathway coordinator on a long-term basis.

The implementation of formalised liaison arrangements between stakeholders (professionals and families) is recommended.

Situations or periods requiring heightened professional vigilance

Periods or situations of transition, whether related to the child/adolescent or to the reception and support arrangements, are recognised as creating difficulties for the child/adolescent, professionals and the family, and therefore require greater vigilance. As autistic people are highly sensitive to change, it is recommended that professionals [GPG 2012]:

- pay greater attention to all transitional situations, both in the daily life of autistic children or adolescents and within their life pathways, whether these situations are linked to the child/adolescent or to changes in support arrangements;
- exercise particular vigilance in the following situations:
  - entry into adolescence,
  - transition to adulthood,

- changes in family circumstances or the child's/adolescent's immediate environment (death, parental separation, departure of a sibling, change of individual special educational needs support assistant, etc.),
- changes in intervention arrangements within the same structure, particularly changes of group,
- change of schooling and/or support setting (first school enrolment, transition from nursery to primary school, transition to lower secondary school, transition to upper secondary school, admission to a medico-social institution, admission to residential accommodation for disabled adults, handover between two intervention teams, particularly between healthcare and medico-social structures and vice versa, etc.),
- handover between diagnostic stakeholders and intervention stakeholders.

It is recommended [GPG 2012] to:

- share observations made individually by each professional (internally and externally), as well as by parents, in order to promote collective vigilance (team meetings, oral and written feedback to parents and professionals, etc.);
- address these situations with the participation of the child/adolescent, whose preparation for change and understanding of its coherence are essential;
- address these situations in collaboration with the parents
- ensure optimal preparation for transitions from one care setting to another (preliminary visits, information-sharing, gradual integration prior to admission to the receiving structure, etc.);
- take account of possible future pathways for adolescents from the age of 16 years, and focus learning activities and administrative or social procedures on the priorities of future adult life, in order to facilitate the smoothest possible transition to mainstream or specialist services for autistic adults;
- ensure the continuity of the support provided and of the tools selected, insofar as they remain adapted to the individual's needs, through the organisation of handovers between teams;
- strengthen support where necessary during these transitional situations.

Support for teams

It is recommended to organise support for teams through collective and regular reflective practice forums (once a month or once a quarter), facilitated by an external third party [GPG 2012].

It is recommended to avoid professional isolation and to enable professionals to work under the guidance of peers, a manager or a supervisor [GPG 2012].

To prevent professional exhaustion and burnout, it is recommended to pay particular attention to team support and to exercise heightened vigilance when a new professional takes up their post or when a trainee is welcomed, as well as during sensitive periods involving difficult situations, particularly those involving risks of violence or following violent incidents [GPG 2012].

Identification of reception and support services within a territory

It is recommended that every structure, regardless of its status or sector, clearly identify the approaches proposed and the specific resources made available to children and adolescents and their families within the local area [GPG 2012].

Early access to interventions, rights and services

It is recommended to:

- implement early interventions, rehabilitation and access to rights without awaiting confirmation of an autism diagnosis;
- use all available resources and organisational arrangements compliant with good practice guidelines in order to facilitate early identification and diagnosis;
- organise territorial directories of identification, diagnostic and intervention services, and publish them on the websites of the primary health insurance funds, autism resource centres, coordination and referral platforms and departmental disability centres;
- encourage the use of tele-expertise in order to facilitate interventions and follow-up for autistic children and adolescents.

11.3. Promoting clinical research

It is recommended to:

- involve experiential experts (autistic people, families and professionals concerned) in research (participatory research);
- encourage frontline professionals, families and children to participate in clinical research projects;
- continue evaluating the impact of recommended interventions on children's pathways and disseminating findings in order to support developments in professional practices.

Glossary

Augmentative and Alternative Communication (AAC): AAC is a comprehensive approach addressing both receptive and expressive communication, with the aim of communicating differently (alternative communication) and more effectively (augmentative communication) than through usual or natural means.

Challenging behaviours: "Culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities" (Emerson, 1995, 2001).

Respite schemes: a respite solution is:

- a means of responding to the needs of carers in order to relieve them within the current caregiving context;
- a means of preventing any deterioration in the situation;
- a set of flexible, evolving arrangements and services adapted to the specific circumstances of each carer. They may be occasional or regular, short term or long term, and may take various forms.

Therapeutic patient education (TPE): TPE aims to help patients acquire or maintain the skills they need to manage their lives as effectively as possible with a chronic condition. It forms an integral and permanent part of patient care. It includes organised activities, including psychosocial support, designed to make patients aware of and informed about their illness, care, healthcare organisation and procedures, and health- and illness-related behaviours. The purpose is to help them (as well as their families) understand their condition and treatment, collaborate and assume responsibility for their own care, with the aim of helping them maintain and improve their quality of life.

Assessment of functioning (also referred to as functional assessment) and functional analysis are two types of assessment with distinct objectives:

- assessment of functioning recommended by HAS (2018), also commonly referred to as multidimensional functional assessment, aims to provide a cross-sectional description of a person's abilities and limitations in adaptive domains (autonomy, communication, social interactions, motor skills, etc.), in relation to their living environments. This approach is grounded in internationally recognised bio-psycho-social models, and supports medico-social and educational guidance and decision-making (ICF-CY, ICD-11, DSM-5);
- functional analysis, is a term used worldwide (particularly in the ABA, ESDM, TEACCH or SCERTS approaches) within an intervention framework. It aims to analyse how the person uses their skills in different environments (family, school, work) in order to define individualised and measurable objectives. It is often dynamic and context-dependent, and supports the implementation of educational, therapeutic or inclusion plans. Functional analysis also corresponds to an interactive model linking challenging behaviours to the patient's cognitions and emotions within a given situation, together with their antecedents, on the one hand, and their consequences, on the other.

Although some tools are shared (e.g. Vineland, ABAS), their use differs according to purpose (overall functional assessment versus fine adjustment of intervention strategies).

Parental guidance: in a natural setting, this involves giving parents a clear explanation of the educational strategies to adopt, demonstrating them and enabling parents to practise them, while providing constructive feedback to help parents appropriate and generalise them in everyday life. This may

involve home visits, video feedback, tutorials, etc. (French Interministerial Delegation for Neurodevelopmental Disorders).

Psychoeducation: psychoeducation is an educational and informational approach targeting people affected by a particular condition who require support to strengthen their adaptive capacities, by providing essential knowledge, improving skills, increasing social support and reducing feelings of isolation.

It may be directed towards several groups: children, adolescents, parents and relatives.

Supervision: supervision of professional practice is a continuing professional development arrangement enabling professionals to apply the knowledge acquired during training to concrete everyday situations. It is based on critical processes (observation, analysis, judgement, intervention) aimed at improving the quality of support provided. It promotes coherence between frameworks, practices and contexts. Preferably conducted with an external third party trained in the relevant methods and techniques, it supports, for example, interventions with autistic children and adolescents, the appropriation of assessment tools, learning strategies and guidance techniques. Supervision is adapted regardless of the professional's mode of practice (in the person's home or within an institution).

Robust AAC systems: robust systems make it possible to communicate everywhere and at all times, thereby enabling the expression of all kinds of messages corresponding to the person's current and future needs. They include a broad vocabulary incorporating different grammatical forms and enabling grammatical development, organised in a coherent and stable manner, allowing for the personalisation of messages and use by the communication partner (and therefore also receptive communication). They are distinguished from basic AAC systems, which respond to a current need and enable the expression of a limited number of communication functions and messages.

Table of annexes

Annexe 1. Questions identified during the scoping phase 66
Annexe 2. Tables and figures 69

Annexe 1. Questions identified during the scoping phase

The topics addressed in the 2012 Haute Autorité de Santé/ANESM guideline remain relevant. However, the recommendations will need to be strengthened, firstly, by the current state of scientific knowledge in 2023 and, secondly, by the shared analysis of experts regarding the resulting practices.

In addition, certain themes will need to be ***explored in greater detail*** in light of the issues encountered in practice. The following questions therefore need to be addressed.

➔ Assessments

How can the various assessments (for diagnostic purposes and for the assessment of functioning) be better coordinated, and how can this lead to the definition of a comprehensive support pathway involving the various existing stakeholders, particularly within the framework of new partnership-based working arrangements (platforms, hubs, groupings, networks, bundled funding schemes, resource centres, outreach teams, etc.)? How can pain identification and assessment, in particular, be better addressed?

➔ Interventions

- What clinical markers/indications can guide the adaptation of interventions to individual situations? How should **associated conditions** (including other neurodevelopmental disorders such as intellectual development disorder (IDD) and attention deficit hyperactivity disorder (ADHD), differing levels of overall development (including high intellectual potential), and age be taken into account? Particular attention should be paid to adolescence, a period conducive to the emergence of associated psychiatric disorders, psychological distress linked to increased difficulties in peer interaction, as well as issues relating to emotional and sexual life (puberty, attraction, romantic relationships and first sexual experiences, etc.) and gender (gender dysphoria).
- Which new intervention programmes or emerging therapies have been scientifically evaluated for effectiveness and safety to a degree providing sufficient evidence to support their recommendation?
- Which models of care and support should be provided for forms of autism spectrum disorder associated with severe challenging behaviours?

➔ The role of the family and carers

- How can family expertise be better incorporated, both in assessment and in the implementation of comprehensive support, and how can parenting support be provided, particularly through “therapeutic education”, “parental guidance”, “co-intervention in rehabilitation workshops”, and “carer training” initiatives?
- How should interventions be adapted in the presence of specific family vulnerabilities (psychological trauma, language barriers, insecure housing, cultural barriers, financial difficulties, etc.)?
- How can greater account be taken of the specific timing and dynamics of each family in defining and implementing the intervention programme for children with ASD? How can the support provided to relatives be mobilised and adjusted according to the progression and key events marking the family history and life course of the child with ASD (diagnostic process, orientation decisions, developmental trajectory of the child, changes in family composition, changes in parental availability and involvement of other family members, etc.)?
- What support should be offered to parents and siblings within a caregiver-support framework? How can risks of caregiver exhaustion be identified? What respite solutions should be offered, particularly in situations involving severe behaviours that challenge or crisis situations?

Beyond the further exploration of themes already addressed in the 2012 guideline, **new issues have emerged and/or raised questions among professionals**, therefore requiring specific analysis.

➔ Digital tools

– What types of technologies/computer functionalities are used to support learning (including school learning), skills development (in communication, social interaction, etc.) and autonomy in children or adolescents with ASD (37)? How relevant is the integration of these technologies into practice?[28]
– In what contexts can digital telehealth tools – notably teleconsultation, tele-expertise and telecare, which developed considerably during the health crisis – be used with children primarily characterised by communication and social interaction difficulties? How can they be used for professional training? What are the indications for their use with parents or with mainstream community partners?

➔ Consideration of autism spectrum disorders within child protection services

Children recognised as disabled by departmental disability centres and supported by child protection services do not always receive the care and support they require.(38)

– How can the consideration of possible autism spectrum disorders be improved in child safeguarding reports concerning children at risk of harm? What specific interventions should be provided for children with ASD receiving support within the child protection system? What forms of collaboration should be established with child protection and judicial services?

➔ Inclusive social activities

As with any disability situation, the aim is to provide social activities that contribute to the child's development, promote varied social interactions within their living environments, and prepare them for adult life.

– How can access to and participation in sporting, cultural, leisure and civic activities for people with ASD be promoted within mainstream local facilities and services?

➔ Self-determination

"Having the power to make decisions for oneself is a learning process that develops throughout a person's life. Self-determination is an essential driver of identity construction for each of us and gives meaning to the concept of full citizenship."(32)

– How can comprehensive support be provided that not only enables children and adolescents, as far as possible, to carry out the various activities expected of a person of the same age without assistance from others, but also develops their ability to make decisions for themselves and take charge of their own lives? How can greater consideration of the person's self-determination and experiential knowledge be given in the definition and implementation of support arrangements?

➔ Schooling

For minors and young adults, school learning and vocational training play a central role in their care and support pathway. Between three and sixteen years of age, minors with ASD are necessarily enrolled in an educational pathway and encouraged to adopt the role of pupil. Over the past ten years, schools have undergone profound changes, notably reflected in the creation of new arrangements serving an increasingly inclusive education system. Whereas schooling was addressed in a short chapter of the 2012 HAS guideline, educational pathways are intended, in the present guideline, to become a central and cross-cutting component of the comprehensive support provided to children, adolescents and young adults with ASD.

[28] It should be noted that the Haute Autorité de Santé will not undertake any technological assessment as part of this guideline update. On the basis of the existing literature and expert discussions, the aim is to indicate the level of evidence supporting the usefulness of these technologies. Gaps in knowledge will also be examined.

– How do care and interventions integrate into educational and vocational pathways, support the child's academic success and foster their fulfilment within the educational community, including alongside other pupils and students[29] (from nursery school through to higher education)?

➔ **The life pathway**

– How can the continuity and consistency of actions undertaken by the various stakeholders throughout the life pathway of children and adolescents with ASD be ensured, particularly in preparing the transition to adulthood?

[29] Article L. 111-3 of the French Education Code: "Within each primary school [école], lower secondary school [collège] or upper secondary school [lycée], the educational community brings together pupils and all those who, within the educational establishment or in connection with it, contribute to the fulfilment of its missions. It includes school staff, parents of pupils, local authorities, educational associations supporting public education, as well as institutional, economic and social stakeholders associated with the public education service. Within the framework of an inclusive school system, its cohesion is founded on the complementarity of expertise."

Annexe 2. Tables and figures

Table 3. Assessment of intellectual functioning in children with ASD: standardised global tests not specific to ASD

Language level	Test	French norms	Time	Organisation	Authors
Non verbal	Snijders-Oomen Non-verbal Intelligence Test SON-R	2½-7 years Standard scores m = 10, σ = 3 and M = 100, σ = 15	> 45 minutes	6 subtests of 15 items SON-Performance SON-Reasoning	Tellegen, 1943, 1958, 1975, 1988
Non verbal	Coloured Progressive Matrices CPM or (PM47)	1998, 1,064 children aged 4 to 11½ years	20 minutes	Paper version 3 series 36 items in total	Raven, 2008
Non verbal	Coloured Progressive Matrices Board Form CPM-BF	> 4 years	20 minutes	3 series 36 items in total	Raven, 2008
Non-verbal and verbal	Standard Progressive Matrices SPM or (PM48)	1938, 1998, 670 children aged 7 to 11½ years	20 minutes	5 series 12 items each	Raven, 2008
Non-verbal	Wechler Nonverbal Scale of Ability WNV	4-8 years Standard scores m = 50, σ = 10 IQ percentile	30 minutes	2 versions (2/4 items) Matrices, coding, object assembly, picture arrangement	Wechsler and Naglieri, 2009
Verbal	Wechsler Preschool and Primary Scale of Intelligence – Fourth Edition WPPSI-IV	Two norming samples 2 ½ years-3 years 11 months 4-8 years	60 minutes	Forms with 7 and 15 subtests 3 scales (full scale, primary and ancillary indices)	Wechsler, 2014
Verbal	Wechsler Intelligence Scale for Children – Fifth Edition WISC-V	6 to 16 years 11 months	60 minutes (shorter than WISC-IV)	15 subtests (including 3 new ones) Full scale and 5 indices: primary and ancillary	Wechsler, 2016

Table 4. Intelligence: severity of intellectual developmental disorder

"The different levels of severity of intellectual developmental disorder are defined [by the DSM-5] on the basis of adaptive functioning rather than IQ score, because it is adaptive functioning that determines the level of support required."

Title	**Vineland-II** **Vineland Adaptive Behaviour Scales, Second Edition (VABS-II)**
Authors	Doll, 1935, 1968 ; Sparrow, Cicchetti, Balla, 1965, 1984, 2005
Psychometric properties	Good internal consistency, confirmatory factorial validity, good discriminant validity Good correlations between the two forms Weak correlations between IQ (Wechsler) and Vineland
Reference frameworks	*American Association on Mental Retardation* (AAMR, 2002), DSM-IV-TR (2000), ICF, 2001, 2011
Forms	Semi-structured interview not requiring the presence of the individual Two forms: interview and parent/practitioner
Structure	Four functional domains (each subdivided into 3 subdomains): communication, daily living skills, social skills and motor skills, and maladaptive behaviours (internalising and externalising), and 383 items
Objectives	Assessment of activity limitations Measurement of the severity of intellectual disability Identification of intervention/compensation focuses Developmental follow-up
US norming sample	3,687 individuals from 44 states Birth-90 years
French norms	French version 2015, ECPA Pearson 1,654 questionnaires and 310 control participants
Administration	Between 30 and 60 minutes, plus 15 to 30 minutes for interpretation
Scoring	Three-point scoring system (2 = activity usually performed; 0 = never performed) No right or wrong answers Focus on what the individual usually does rather than what they might be capable of doing
Scores	Conversion of raw scores into standard scores according to chronological and/or developmental age (subdomains): overall, by domain and subdomain Composite total: m = 100 and σ = 15 Subdomains: m = 15 and σ = 3
Prerequisites	Verify the competence of the respondent and establish a good interviewer/respondent relationship Experience in data-gathering interviews and interpretation of tests Identification of the relevant “developmental window” Training strongly recommended
Prospective	Vineland 3 released in the USA in 2016

Table 5. Clinical assessments specific to ASD

Tests	Reference	Standardisation	Administration	Structure	Training	Author
Psycho-educational profile **PEP-III**	Concept of emergence Developmental profile Educational intervention	2-7 years Developmental ages	45 to 90 minutes 3-point scoring 172 items	3 categories: communication and motor skills, maladaptive behaviours	Necessary	Schopler, 1979, 2004, 2008
Sensory Profile **Sensory Profile** **SP**	Sensory processing, modulation and behaviours Hyper- and hypo-reactivity	3 to 10 years 11 months 1,037 Americans 561 French participants	30 minutes for the long version 10 minutes for the short version 125 items	2 child versions	Necessary	Dunn, 2010
Batterie d'évaluation cognitive et socio-émotionnelle (Cognitive and Socio-Emotional Assessment Battery) **BECS**	Positions: Piaget, Bruner and Fischer	4 to 24 months (divided into 4 periods)	196 items	16 domains and 2 profiles: cognitive, socio-emotional	Necessary	Adrien, 2007
Early Social Communication Scales **ESCS**	Communicative behaviours (Bruner and Bates) Fischer's neo-Piagetian positions	3 to 30 months Developmental levels in the targeted domains	40 minutes 23 situations and 108 items	3 dimensions: social interaction, joint attention and behavioural regulation	Necessary	Seibert and Hogan, 1982 Guidetti, Tourette, 2009
Imitation Scale **IS**	Perception/action coupling Mirror neurons	Assessment of motor skills, means-end relationships and synchrony	45 minutes 4-point scoring 36 items	3 dimensions: spontaneous imitation imitation on request and recognition of being imitated	Necessary	Nadel, 2011, 2015
Test of Pretend Play - **TOPP**	Object substitution, attribution and reference	American norms 1-6 years	45 minutes	2 versions: verbal (over 3 years old) and non-verbal	Necessary	Lewis and Boucher, 1998

Quality of life score **Par-DD-QoI**	Impact of developmental disorders on parental quality of life	590 parents of typically developing children 349 parents of children with atypical development	17 items 10 minutes	3 dimensions: adaptive emotional and total	-	Raysse, 2011
Aberrant Behavior Checklist **ABC**	Assessment of treatments in developmental delay	927 institutionalised individuals 5-58 years	58 items Scoring from 0 to 3 (intensity)	Five-factor structure	-	Aman, Sing, Steward et Field, 1985

Table 6. Assessment of psychomotor or neuromotor functions

Below are examples of assessment tools for psychomotor, neuromotor or movement-related functions. These tools are not specific to ASD but are regularly used with children with neurodevelopmental disorders (NDDs).

Instruments	Author	Indication	Age	Organisation
Batterie d'évaluation des fonctions neuropsychomotrices de l'enfant **NP-MOT (Assessment Battery for Children's Neuropsychomotor Functions)**	Vaivre-Douret, 2006	Examination of sensory integration and neuromotor systems	4-8 years French standards Standardisation by sex, school level and function 446 boys and girls	Qualitative and quantitative observational items covering 9 functions: muscle tone, gross motor skills, laterality, manual praxis, tactile gnosis, visuomotor abilities, spatial orientation, rhythm, auditory attention
Développement fonctionnel moteur **DF-MOT (Functional Motor Development)**	Vaivre-Douret, 1999	Assessment of posturo-motor development and grasping, visuomotor coordination	0 to 48 months French standards 123 children followed longitudinally	Precise description of targeted and standardised behaviours
Movement Assessment Battery for Children **M-ABC2**	French adaptation Marquet-Doléac, Soppelsa and Albaret, 2016	Assessment of motor skills: delays and disorders	3-17 years by age bands French standards 626 children	Three domains and eight tasks: manual dexterity, aiming and catching ability, static and dynamic balance
Concise Evaluation Scale for Children's Handwriting **BHK and BHK Ado**	French version: Charles, Sopplesa and Albaret, 2004 and 2013	Early identification of dysgraphia and handwriting disorders	From Year 1 to Year 5 837 children From the first to the final year of lower secondary school 471 participants French standards	5-minute text-copying exercise 13-item scale

Table 7. Assessment of communication and language

Below are examples of tools used to assess communication and language, as well as pragmatics and social skills. Some are not specific to ASD but are regularly used with children with neurodevelopmental disorders.

Tests	Authors	Assessment	Administration	Access to resources
Nouvelles épreuves pour l'examen du langage **N-EEL (New Assessments for Language Examination)**	Chevrie Muller; Plazza; Fournier and Rigoard, 2001	Comprehensive assessment of language components (comprehension and production) Word-finding difficulties and lexical access difficulties	3 years 7 months to 8 years 7 months 17 subtests 2 protocols: Form P (younger children) and G (older)	Paid access
Évaluation des stratégies de compréhension en situation orale **O52 (Assessment of Oral Comprehension Strategies)**	Khomsi, 1987	Oral language comprehension disorders across 52 statements	Standardised scores for ages 3–7 Immediate and global comprehension	Paid access
Clinical Evaluation of Fundamental Language Concepts **CELF CDN-F**	French version Wigg et al. 2009	Receptive and expressive language skills Highly sensitive to language difficulties	520 children 4-8 years and 9-16 years 19 subtests including 4 required to obtain a Core Language Score (CLS)	Paid access
Épreuve de compréhension syntaxico-sémantique **E.co.s.se (Syntactic-Semantic Comprehension Assessment)**	Lecocq Inspired by TROG (Test for Reception of Grammar, Bishop, 1983)	Assessment of oral and written syntactic-semantic comprehension	4-12 years Oral standardisation on 2,100 children 20 minutes	Paid access
Test of Pragmatic Language-2 **TOPL-2**	Phelps-Terasaki and Phelps-Gunn, 2007	Pragmatic skills and deficits	2 booklets (6 to 18 years 11 months) 45 minutes Standards	French translation available through the autism resource centres
Peabody Picture Vocabulary Test **PPVT**	Dunn, Theriault-Whalen and Dunn, 1993	2 forms A and B, each with 175 plates Canadian standardisation on 2,028 children and adolescents	2 years 6 months to 18 years 8-15 minutes 170 items (1 picture selection out of 4)	Paid access
Forerunners in Communication assessment tool **COMFOR2** **(also known as "ComVoor")**	Verpoorten, Noens, and Van Berckelaer-Onnes, 2012	Recommendations for implementing augmentative and alternative communication (AAC)	No verbal instructions 45 minutes. 36 items of increasing complexity, organised into 5 series with 2 levels (sensory or functional). Each item is a sorting, fitting or matching task	Paid access

Table 8. Recommended tools for structuring observations carried out by teams supporting children/adolescents with ASD (non-exhaustive and evolving list)

Objective	Domains assessed	Tools
Describe the child/adolescent's profile	Several domains	Childhood Autism Rating Scale (CARS-2) (from 2 years to adulthood) Vineland Adaptive Behavior Scales (VABS-II and VABS-3) (from 0 to 18 years) Autism Behaviour Scale from 2.5 years to 18 years
	Early social interactions	Early Social Communication Scale (ECSP) (from 3 to 30 months)
	Behaviour	Functional behavioural assessment in cases of challenging behaviour
	Language and communication	Standardised tools not specific to ASD
	Sensori-motor functioning	Standardised tools not specific to ASD
Identify emerging abilities	Several domains	PEP-3 (from 6 months to 12 years) AA – PEP (adolescents and adults)

Table 9. Recommended tools for structuring observations carried out as part of additional assessments (non-exhaustive and evolving list)

Objective	Domains assessed	Tools
Determine the child's/adolescent's developmental levels across different domains in comparison with their chronological age	Cognitive and other domains	BECS (tool specifically designed for autistic children, adapted regardless of intellectual development or language level, assessing functions developing between 4 and 24 months and standardised with children up to 10 years of age) Brunet-Lézine (non-specific tool for children under 3 years of age) WPPSI-III (children aged 0–6 years), WISC-IV (children/adolescents aged 6–16 years) or KABC-II (children aged 3–13 years) (tools not specific to ASD and not suitable when the child has not developed verbal language) PEP-3 (6 months to 12 years) or AA-PEP (adolescents and adults), tools specific to autistic people

Table 10. Main intervention programmes

Name	Type of approach	Age	Skill domains	Prerequisites	Implementation	Parent guidance	Training and certification	Practice supervision
ABA ***Applied Behaviour Analysis***	Behavioural and cognitive-behavioural	All ages	All developmental domains	None	All environments	Yes	Yes University training, continuing professional development and certifications	Yes
JASPER ***Joint Attention, Symbolic Play, Engagement, and Regulation***	Developmental Behavioural	12 months to 8 years (children with limited language)	- Joint attention - Engagement - Play - Regulation Progressive increase in the pace and complexity of social communication	Conducted in a small space adapted for play, with toys suited to the child's developmental level. Containers to organise toy storage. AAC should be made available if used by the child, as well as any other visual supports and positive behavioural supports	All environments	Yes	Yes	Yes
ESDM ***Early Start Denver Model***	Behavioural and developmental	To be initiated between 1 and 3 years and continued up to 5 years	Requesting Verbal imitation and gestures	Developmental age must not be below 7–9 months.	The programme may be implemented in all living environments,	Yes	Yes	Yes

			Naming/commenting Understanding instructions Describing objects according to function, category and characteristics Responding verbally in interactions Reading words Writing heard words	The child must be "interested in objects and able to use some simple means–end actions" If the child has a developmental age above 4 years in all domains, this programme is not suitable.	including home, nursery/school and care settings where applicable.			
TEACCH ***Treatment and Education of Autistic and related Communication handicapped Children***	Developmental	All ages	All developmental domains	None	All environments	Yes	Yes Certified training	Yes
TED **Thérapie d'échange et de développement (Developpment and**	Developmental	From 12 months	Foundations of non-verbal communication Social interaction Language	None	Conducted in a neutral white room set up in a place regularly attended by the child in order to facilitate communication and interaction	Yes	Yes University training	Yes

Exchange Therapy)			Generalisation phase					
PACT ***Pediatric Autism Communication Therapy***	Behavioural	From 12 months to a maximum of 10 years	Social communication Shared attention Intentional communication Pragmatics	The participating parent must use the language most commonly spoken at home during play sessions and may use a second language for video feedback with the therapist or work with an interpreter.	One 1- to 1.5-hour session every two weeks with a practitioner trained in PACT. 30 minutes of daily play implementing the PACT objectives established during the session. In the natural environment	Yes (with video analysis)	Yes	Yes

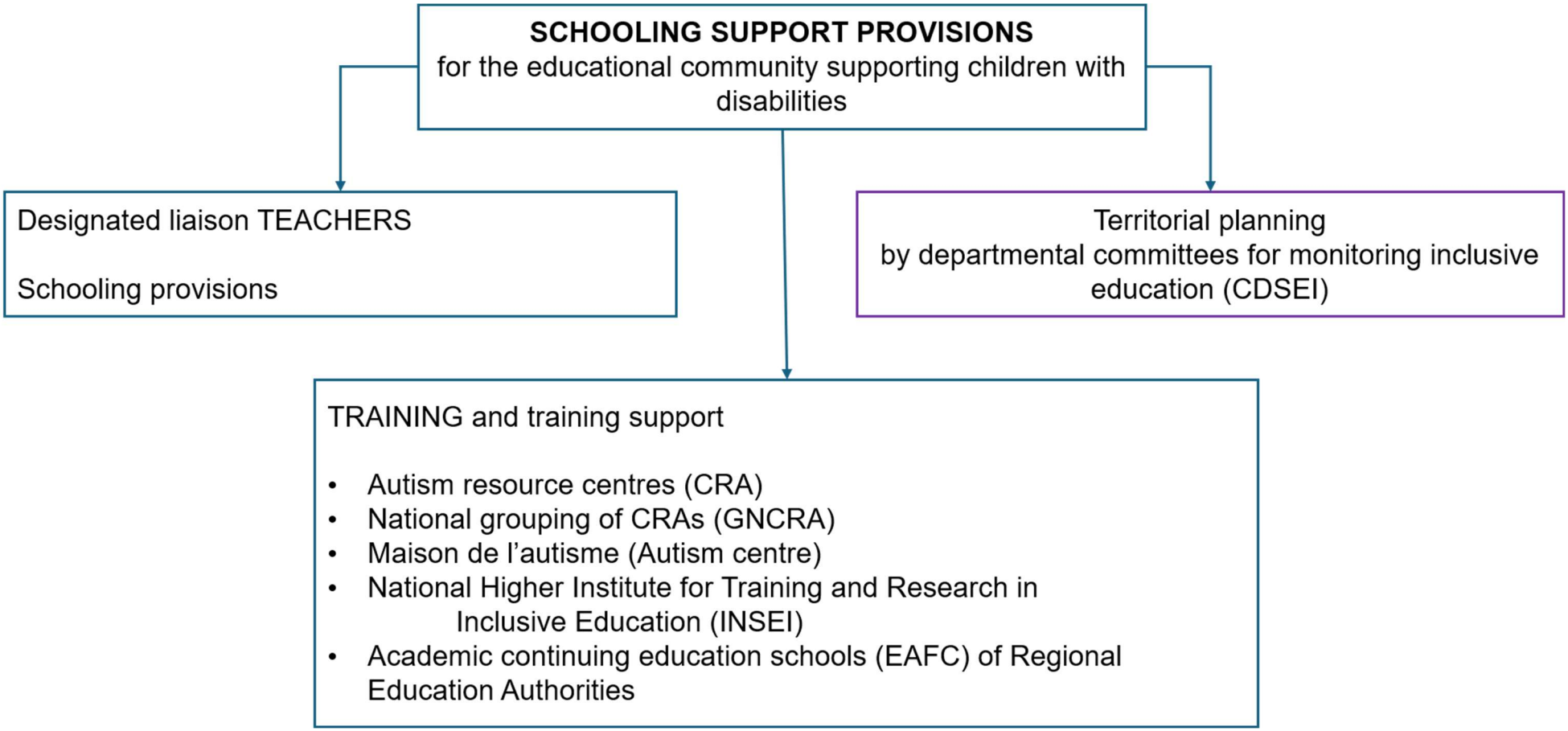
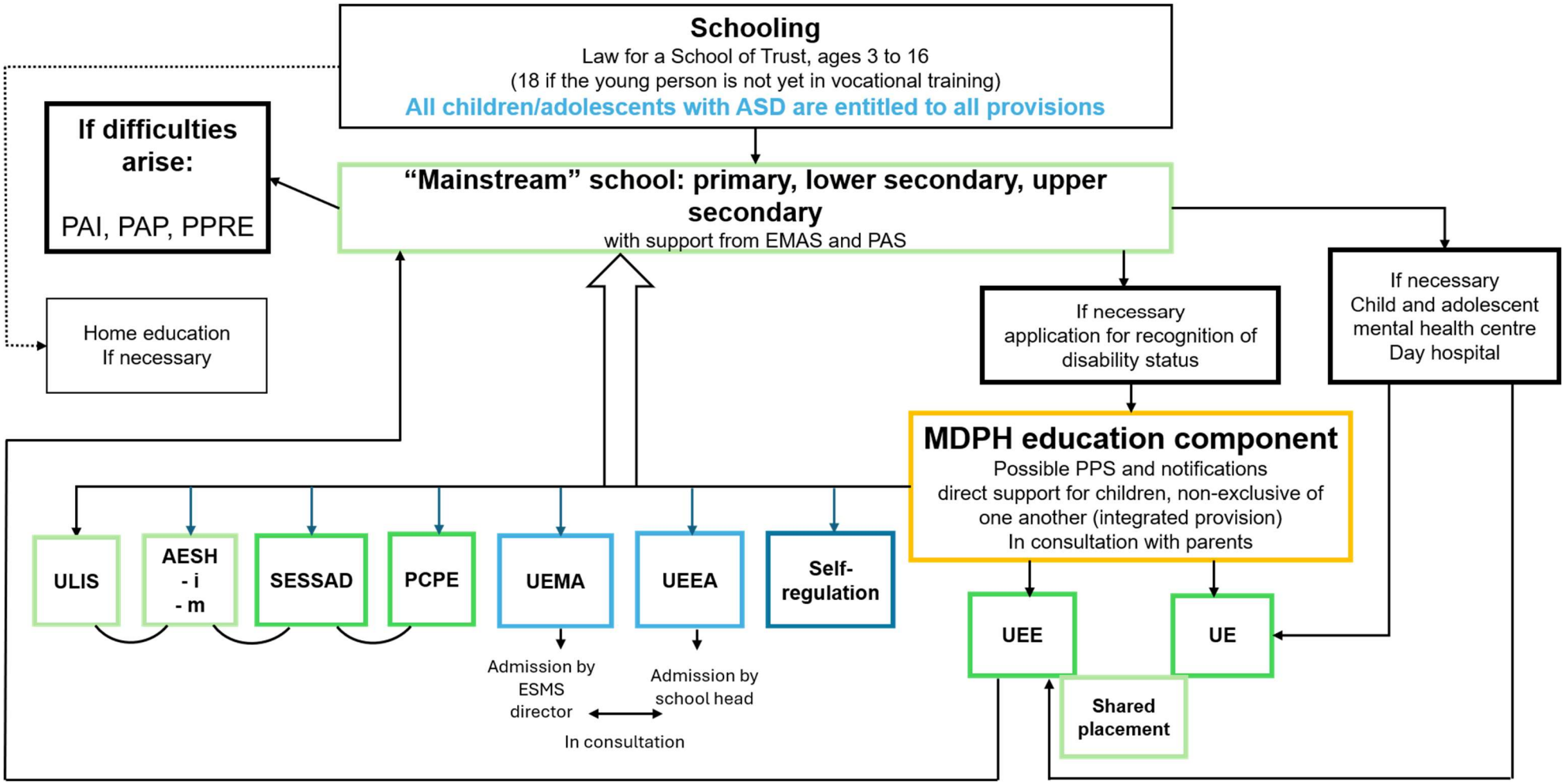


Figure 1. Diagram of the schooling pathway of an autistic child (as of 23 June 2025)

(*Figure 1 continued*)



AESH: special educational needs support assistant; ASD: autism spectrum disorder; EMAS: mobile school support teams; ESMS: social and medico-social facility; i: individual support; m: shared support; MDPH: departmental disability centre; PAI: individualised management plan; PAP: personalised support plan; PAS: schooling support centre; PCPE: specialised support and outreach service hubs; PPRE: individualised programme for academic success; PPS: personalised schooling plan; SESSAD: special education and home care service; UE: teaching unit; UEE: outreach teaching unit; UEEA: autism-specific primary teaching unit; UEMA: autism-specific nursery teaching unit; ULIS: localised unit for inclusive education

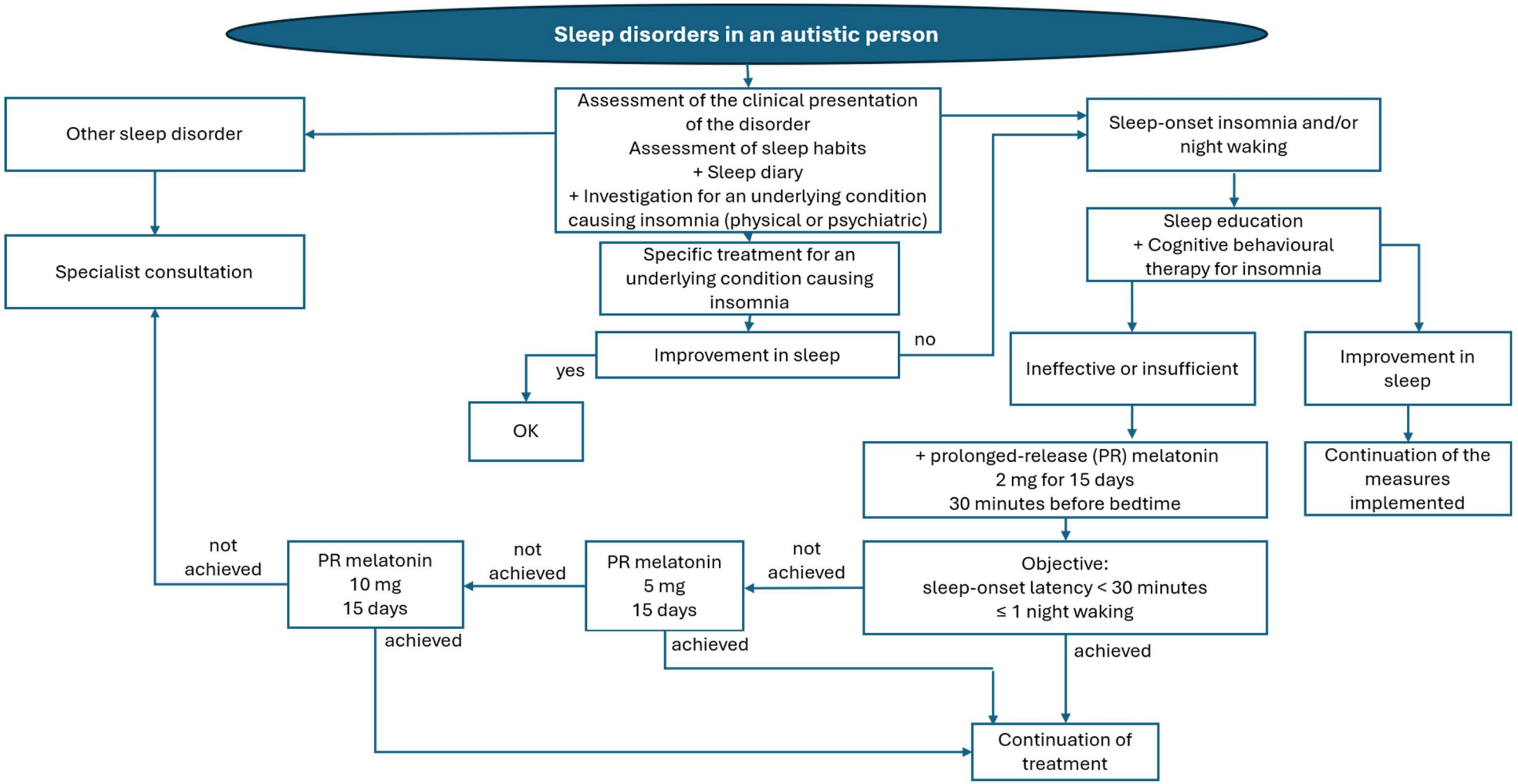


Figure 2. Management of sleep disorders in an autistic person

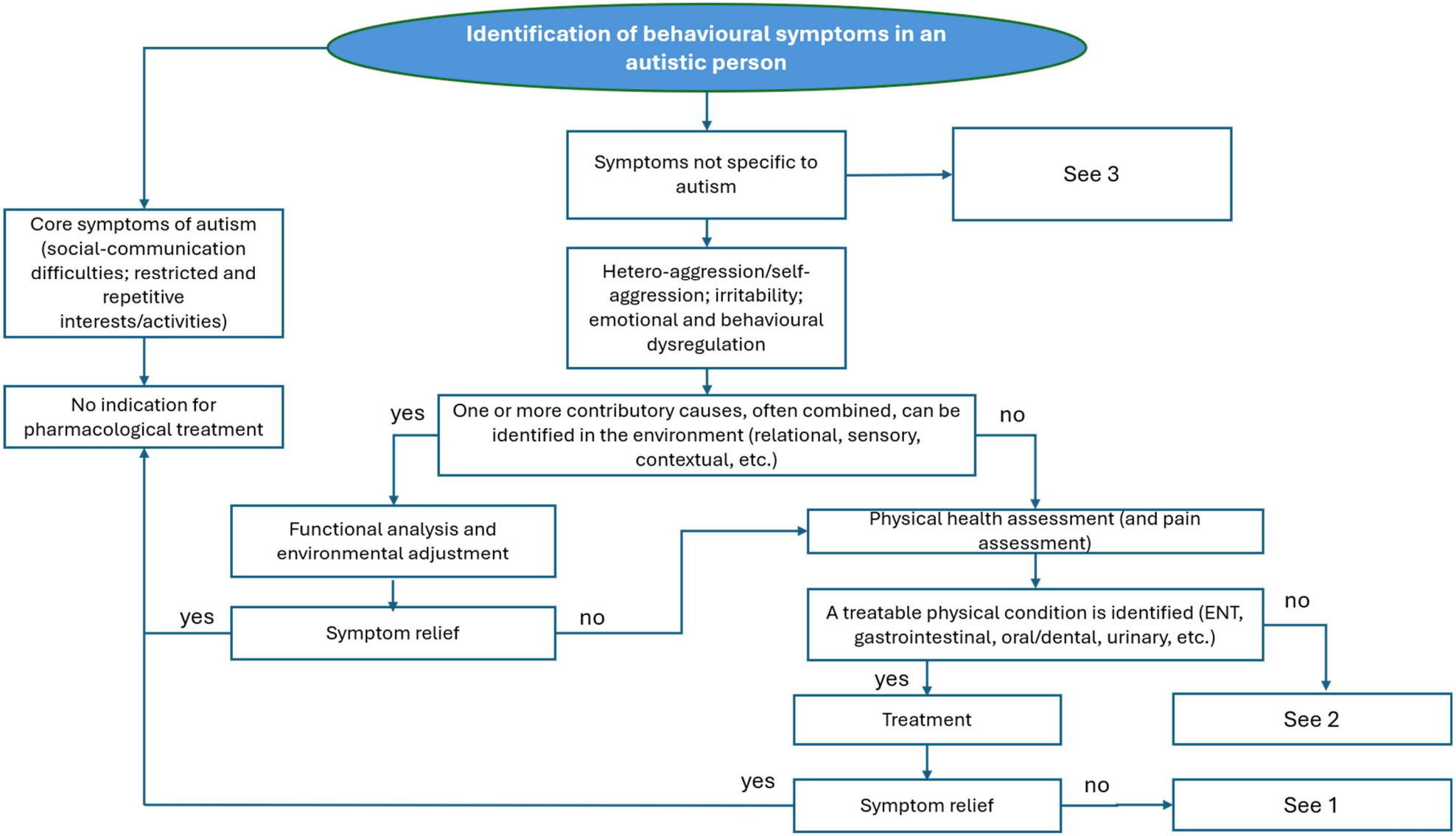
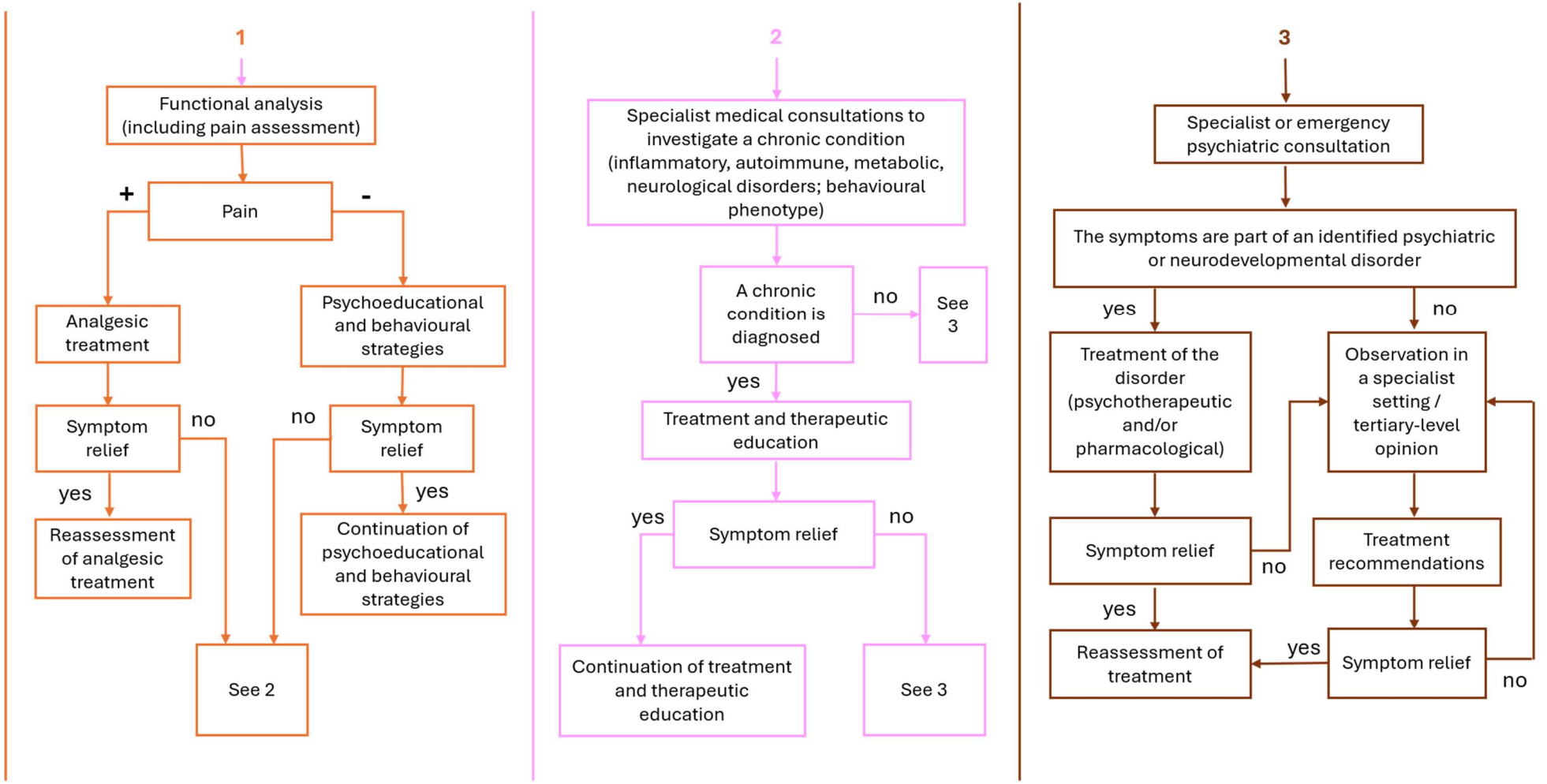


Figure 3. Management of behavioural symptom identification in an autistic person

(*Figure 3 continued*)



Participants

The following professional bodies and patient and user associations were consulted to propose experts invited individually to take part in working/review groups:

Agir et vivre l'autisme

Alliance les 4 A

Association Autisme espoir vers l'école (AEVE)

Association Autisme France

Association Autistes sans frontière

Association CLE autistes

Association française de gestion de services et établissements pour personnes autistes (AFG Autisme)

Association française de promotion de la santé scolaire et universitaire (AFPSSU)

Association nationale des équipes contribuant à l'action médico-sociale précoce (ANECAMSP)

Association nationale française des ergothérapeutes (ANFE)

Association Personnes autistes pour une autodétermination responsable et innovante (PAARI)

Association pour la recherche sur l'autisme et la prévention des inadaptations (ARAPI)

Association Rassemblement pour une approche des autismes humaniste et plurielle (RAAHP)

Caisse nationale de solidarité pour l'autonomie (CNSA)

Center of excellence for Autism and Neurodevelopmental Disorders (CeAND)

Centre d'excellence autisme et troubles du neurodéveloppement (iMIND)

Centre d'excellence des troubles du spectre autistique et neurodéveloppementaux d'Île-de-France (InovAND)

Collège de la masso-kinésithérapie (CMK)

Collège de la médecine générale

Collège infirmier français

Collège national d'orthophonie

Collège national pour la qualité des soins en psychiatrie (CNQSP-CNPP)

Collège national universitaire de psychiatrie (CNUP)

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Conseil national professionnel de psychiatrie

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Fédération française des psychologues et de psychologie (FFPP)

Fédération française des psychomotriciens (FFP)

Fédération française Sésame Autisme

Groupement national des centres de ressources autisme (GNCRA)

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Association APF France handicap

Croix-Rouge française

Direction générale de l'Enseignement scolaire (DGESCO)

Nexem

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M. Corentin Gosling, neuropsychologue, Nanterre

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Alterergocare

Association Allier Sésame Autisme

Association Autisme 69

Association Autism'Aide 56

Association Autisme Amiens ASF80

Association Autisme Charente-Maritime

Association Autisme Choix Rationnel d'Inclusion 46

Association Autisme Côte d'Émeraude

Association Autistes dans la cité

Association Autisme Deux-Sèvres

Association Autisme France

Association Autisme Landes

Association Autisme Pau Béarn Pyrénées

Association Autisme Savoie

Association Autisme Sénonais Vers l'Autonomie

Association Autisme Tregor Goëlo

Association Autisme Vienne

Association des œuvres laïques

Association Détours

Association Éclat

Association Envol Lorraine

Association Fondation Bompard

Association française de pédiatrie ambulatoire

Association française des étudiants et professionnels en psychomotricité

Association France TND

Association Gabriel Deshayes

Association Isaac Francophone

Association j'Existe

Association La Voie Rêvée

Association Le relais atypique

Association Les Papillons Bleus Zébrés

Association nationale des équipes contribuant à l'action médico-sociale précoce

Association française des psychologues de l'Éducation nationale

Association nationale française des ergothérapeutes

Association Ornéode Samsah TSA

Association Parents ensemble

Association Planète Autisme

Association pour adultes et jeunes handicapés (APAJH) 04

Association pour la recherche sur l'autisme et la prévention des inadaptations

Association pour le traitement, l'accompagnement, les soins et le handicap

Association prévention autisme recherche

Association Quand un sourire suffit

Association Respir Bourgogne

Association Sésame Autisme Cher

Association Soleil Corrézien autisme

Association Soliane

Association TED – Autisme – Intégration Vaucluse

Association TED et les autres

Association Tous en bleu solidarité autisme

Association Tous pour l'inclusion

Association Tous Solidaires Autisme 93

Association TypiK'AtypiK

Association Une étincelle d'espoir pour Soan

Association Vivre Avec l'Autisme 32

Autoreprésentativité et Autoreprésentation Collectives de Personnes Handicapables

BIOCODEX

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Hand-AURA

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IME Les Coteaux d'Azur

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IME Les vallées et SESSAD de l'Yerres

IME Saint-Jean de Plaisance

Ladapt Essonne

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Personnes autistes pour une autodétermination responsable et innovante

POC TND 42-43

Pôle ambulatoire ADEI 17

Sessad APAJH, Bar-le-Duc

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Union régionale Autisme France Poitou-Charentes

URPS Orthophonistes des Pays de la Loire

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