



ASD Connector

September 2015

Volume 43



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Collaboration is a big part of what we do at the ASD Clinic. For the children and youth with complex and high risk challenges, that we serve, it can take multiple perspectives to determine their unique profile of needs and how best to move forward. Though sometimes it takes more effort to be open to and consider others’ views, we learn a lot from each other to better understand and address these challenges. I’m please that, within this edition, some clinicians collaborated jointly to write their submissions.

A big thank you to all our readers who completed our May survey. Your feedback will help to guide future editions. Also, a thank you goes to summer student Neil Dixon-Crawford, who has given this newsletter a new look.

May you, too, be open to the evidence that different perspectives and ‘new looks’ can bring to serving those with ASD.

- Patty Petersen, editor

CPRI Mission

Our mission is to enhance the quality of life of children and youth with complex mental health or developmental challenges and to assist their families so these children and youth can reach their full potential.

CPRI

CHILD & PARENT
RESOURCE INSTITUTE

**Child and Parent Resource Institute (CPRI)
Autism Spectrum Disorders Clinic / ASD2 Clinic**

600 Sanatorium Road, London ON N6H 3W7
519-858-2774 | cpri.ca

WHEN LESS IS MORE

By Joan Gardiner, Speech-Language Pathologist, ASD Clinic

Language is pretty amazing. It is a system of communication that we, as humans, have developed over thousands of years. It allows us to share information with others for all sorts of reasons and to gather information from them as well. We can use language to inform, to comment, to greet, to request and to connect.

For most of us, learning language comes easily; it just sort of happens. From just the short time between when we are infants to when we go to school, we learn thousands of words and we figure out how to combine these into an infinite number of phrases and sentences. And, as we continue to develop, we learn to use language for increasingly sophisticated purposes. Most of the time, having language is a powerful tool.

Importantly though, there are times when language is of less value. These times tend to be when our attention is diverted from the higher-level cognitive (i.e., thinking) tasks that language helps us to complete; when our attention is instead, focused more on emotions and perhaps even a sense of survival. These are times that other systems of the brain and body take over (e.g., anxiety, hyper-arousal, fight-or-flight reactions) and language becomes less relevant (and perhaps, even a burden).

For all of us, there are times when we just need a little quiet. Perhaps after a long busy day, perhaps when we need to concentrate on a specific task that we have to complete, or perhaps when we are feeling irritable, bothered, unwell or anxious. Usually, we are able to let those around know that we need a quiet break (ironically, we use language to do this) and so, they are able to leave us alone and/or to give us a quiet moment for ourselves.

Individuals with autism also have times when language can become a burden. This statement applies to those who are non-verbal (but who have communication partners and caregivers who talk to them) right through to those who are very verbal (and as such, interact with their world primarily through language). The statement applies because children and adolescents with ASD, like us, have times when they experience feelings of being overwhelmed, frustrated, anxious, or irritable. In fact, they probably experience these feelings many more times a day (or hour) than most of us! A complication for individuals with autism though, is that they often do not know to or cannot use language to let us know that they need a little quiet. Instead, they show us their emotions and experience in the moment via their behaviour (and sometimes, they use problem behaviour).

Unfortunately though, when we encounter someone who is having a difficult moment (including children or youth with ASD), one of the strategies that we innately use to help is to add language to the situation. For example, we ask questions (“what’s wrong?”), make comments (“that’s too bad”) or worse, use language to try to help problem solve through the situation in the moment (e.g., explaining, rationalizing, negotiating or counselling). Unfortunately, what occurs when we try to help in these ways though, is that we end up adding to the burden for the distressed person rather than helping. When they are least able to process and benefit from language, we add more.

To support individuals with ASD then (and quite frankly, all of us), one of the recommendations that I often give when a person is upset, bothered, agitated or in any way dysregulated is to employ a strategy *other than* using language. Instead of talking, use supportive silence; say little or nothing in the moment. Be certain to keep the upset person safe (e.g., say “stop” if he is about to run into the road) but minimize the words and sentences that are directed to or used around him. Apply this

strategy for those who have access to little language or to those who use it for all of their interactions and daily living activities.

I guess then, that, when it comes to language, sometimes the old adage of “less is more” rings true. While those of us who specialize in the area of language and communication hate to admit it, sometimes saying *nothing* is more useful than saying anything.

PLANNED IGNORING

**By Kaylan Bartholomew, Community Behaviour Consultant, ASD2 Clinic and
Dr. Louise LaRose, Board Certified Behavior Analyst-Doctoral, Psychologist, ASD Clinic**

If we had a nickel for every time a parent of a child with ASD told us that using planned ignoring didn't work as instructed to stop their child's negative behaviour, we would have enough money to retire! It seems that often parents, caregivers and educators are informed if you don't want a child to do something, just ignore it and the problem behaviour will stop. This may work some of the time; however, more often than not it doesn't seem to make a difference or sometimes can even make the problem behaviour worse. When deciding whether to use planned ignoring, there are two important considerations: first, the conditions when planned ignoring would be useful to stop problem behaviour and second, how to implement planned ignoring effectively.

Planned ignoring, as a behaviour strategy, is used when the purpose of the child's problem behaviour is to get attention from others. It is not an effective response strategy if the reason behind the problem behaviour is anything other than getting attention. Planned ignoring will NOT stop behaviour that is being used to escape a situation, seek out stimulation, or gain access to an item/edible. When responding to problem behaviour, it is always helpful to know what the child is gaining from doing the problem behaviour. This is done by looking at what is happening both before and after the problem behaviour occurs.

There is also a lot of misunderstanding about what exactly is planned ignoring. It is not about ignoring the person per se; rather, it is about ignoring the behaviour. Think of it in terms of when someone to whom you are talking asks you a rude question. You can just continue the conversation as if the person did not ask that question at all. An example of using planned ignoring with your child is if your child is doing something undesirable that you know is to get your attention, you can briefly shift your attention to another thing or person, and when the behaviour stops, then you give attention back to the child. You have to make sure that no other person around will give the attention when the undesirable behaviour is happening.

If you do decide to use planned ignoring as a way to reduce undesirable behaviours for gaining attention, there are a couple of things to remember as planned ignoring often works best when used with other behaviour change techniques.

- 1) Teach the child a better way to request the attention (for example, touching your arm, using a picture, saying a word, etc.); be sure that you respond to every attempt the child uses to ask for attention with just as much attention as he would have gotten from the undesirable behaviour.
- 2) Look for early signals your child may want attention and prompt him to ask using the replacement behaviour; again be sure you reward these early attempts with just as much attention as the undesirable behaviour would have gotten.

- 3) Make sure you give the child lots of quality attention throughout the day; invite him to be part of what you're doing, gives lots of hugs, quick games, etc.
- 4) Remember: until now the undesirable behaviour has been the easiest way for your child to get the attention from you; in the beginning, be sure the replacement behaviour is even easier for them to do.
- 5) It is possible that, by ignoring the undesirable behaviour, the child may try more of it (escalate) as a way to get the attention; if you use planned ignoring you cannot respond to this new escalating form of the undesirable behaviour or you are accidentally strengthening it and teaching the child again that the easiest way to get your attention is to persist even more.
- 6) Lastly, when using planned ignoring, as soon as there is a pause in the child's undesirable behaviour you can direct him to use the agreed upon replacement behaviour; then reward any attempt at this point by the child to use the replacement behaviour.

Planned ignoring can work as a behaviour change technique, but there is more to it than just planning to ignore. We need to reinforce all the behaviours we want to see and any attempts made to gain our attention in positive ways. Though changing the behaviour of a child with ASD can be difficult and requires careful effort on our part, it is well worth the effort.

OUR ROLE IN THE 'HONEYMOON' ENDING

By Patty Petersen, Board Certified Behaviour Analyst, ASD2 Clinic

Sometimes, when children or youth with disabilities transition to a new situation (such as with a new educator or new activity) or environment (such as a new classroom or residence), an increase in problem behaviour happens initially as they adjust to different expectations, people and/or activities. However, sometimes with the transition, problem behaviour does the opposite: it decreases right away then later, perhaps even weeks or months later, it increases. This period of initial decrease in problem behaviour has sometimes been referred to as a "honeymoon period" and the later increase in problem behaviour has been called the "honeymoon ending."

Some may claim that this is just what the child or youth does, as though the initial decrease then increase in problem behaviour is happening due to qualities internal to the child or youth. Yet, what is known from the science of behaviour is that when changes in the environment (such as switching from predictable to new and unfamiliar conditions) result in problem behaviour reducing then later increasing, it is likely the environmental changes that are causing the behaviour to change, not qualities internal to the child or youth. The good news then, is that when we determine what is changing in the environment, we can put strategies in place to reduce problem behaviour more effectively long-term.

"The Honeymoon"

Let's first explore what might be happening when the problem behaviour initially decreases with the transition to a new situation or environment (i.e. "the honeymoon"). At the beginning of a transition, often staff or caregivers give lots of attention to the child or youth in order to get to know him better and to help him with the adjustment. If previously the problem behaviour served as a way for him to get attention, then his problem behaviour isn't as needed since he is already getting lots of attention for 'free' (i.e he doesn't have to behave to get it). Similarly, in a new situation or environment, there may be novel and interesting experiences for the child or youth to participate in. If, in the past, her problem behaviour had been a way for her to get stimulating experiences, again her problem behaviour is unlikely to occur now since currently she is getting lots of 'free' stimulation. As well, to help with the

adjustment in a new situation or environment, staff and caregivers may begin with few task demands and provide lots of assistance to the child or youth. If previously, his problem behaviour worked to escape from task demands, his problem behaviour is less likely to happen now since there are few task demands from which to escape.

“The Honeymoon Ending”

What could be happening in the environment with time, then, to lead to that increase in problem behaviour (i.e. “the honeymoon ending”)? Perhaps due to other demands on their time or to promote the child or youth’s independence, caregivers or staff may increase expectations for him to work by himself or to keep himself occupied longer. Under these changing conditions of now receiving less attention, the previous problem behaviour, that was effective to get attention, may again increase. Additionally, with time, the once stimulating new experiences may become ordinary and less stimulating. Understandably then, her problem behaviour, that in the past lead to getting more stimulating experiences, is more likely to increase again. Similarly, perhaps to promote greater learning and responsibilities, with time staff or caregivers are apt to increase task demands for the child or youth which may, inadvertently, result in an increase in his problem behaviour for escaping such task demands.

Is the recommendation, then, to continually give the child or youth your undivided attention, or to give her an endless flow of new and stimulating experiences, or to never increase task demands? Definitely not! In order for every child and youth to learn and participate actively in their lives, it is important for each to have a balance of being able to spend time with others and alone; to participate in both new and stimulating experiences as well as ordinary and familiar ones; and to have increasing task demands that challenge new learning.

Teaching

We can achieve this better balance without a dramatic increase in problem behaviour by teaching the skills the child or youth needs to learn. The function of the problem behaviour determines what needs to be taught – does the problem behaviour result in him getting attention, getting increased stimulation and/or escaping task demands? When we have this information, then we can determine what to teach:

For an attention function, teach both:

- to request attention (e.g. “come play”; “read to me”, tap on the arm, etc.) and
- to spend gradually longer time alone (e.g. independent play, leisure or work time)

For a novel stimulation function, teach both:

- how to request novel stimulation (e.g. to request specific items with words or pictures) and
- to spend gradually longer time without novel stimulation (e.g. alternate between novel stimulation and routine tasks)

For an escape function, teach both:

- to request an escape (e.g. “break”, “finished”, “Help”, etc.) and
- to spend gradually longer time at task demands

Importantly, match all teaching to the child or youth’s unique profile of abilities (i.e. intellectual/cognitive, adaptive, communication, and motor). With this plan, maybe the honeymoon doesn’t need to end?

A GOOD QUESTION TO ASK

By Grace Hawes, Case Management Coordinator, ASD Clinic/ Intake and Patty Petersen, Board Certified Behaviour Analyst, ASD2 Clinic

Children with developmental and/or mental health disabilities definitely are not all the same. Each can have a unique presentation, in both their strengths, interests, abilities, and their needs. Similarly, families of children with disabilities can be quite different, in what they do well and also in what they might find challenging. One way service systems (such as children and youth services, education, and health) try to address all these differences is by offering services based on diagnosis, specific criteria, and/or some form of presenting need.

However, sometimes children and/or families, who present with unique, multiple, and/or complex needs, do not seem to be a good fit for existing services or such services might not be able to address the needs. What happens then? More and more, service systems are trying to be flexible in how they meet the needs for these children and/or families. This has resulted in the provincial government initiatives of *Moving on Mental Health* and *Special Needs Transformation*.

Identify the need

In order to come up with a flexible plan though, the service system first must know that such a unique need exists; someone has to identify it or ask for help. The best people to do this are those directly involved, such as the child or youth (if able) and/or the family.

Families might hesitate to ask for help for several reasons: possibly, they believe that their need isn't great enough to warrant help; perhaps they feel it is their responsibility to care for their own and their child's needs, no matter how great; maybe they are uncertain where to turn to for help; they could be too involved in the daily challenges to really identify the help needed; or perhaps their past attempts to get help haven't worked so well and they no longer try.

However, such unique needs can become even greater and more complex if not addressed early. And if families become exhausted in their attempt to address the need alone, they are less able to be there for their child long-term.

Communicate the need

The next step then is for someone (like the child or youth (if able), the family, and/ or another care provider) to communicate the identified need to the service system. But, the service system can seem big and it can be daunting to figure out who to talk to about the specific need. Where to begin? The following are some possible ideas of where to turn for help:

1. Primary resources – family health team/ family doctor/ nurse practitioner or educators at your child's school
2. Secondary resources – pediatrician, local children's rehabilitation centre or resource centre, employee assistance program (EAP) benefits, your community's single point of access/ local access mechanism
3. Helpful websites – such as Autism Ontario, community health unit, telehealth, your city/county website

Your primary or secondary resources may be able to help you directly or may refer you to more specialized services known as tertiary care services. CPRI is a tertiary care service.

Remember, when you're struggling with your child, it is good to ask questions in order to get the help you need.

F-WORDS IN CHILDHOOD DISABILITY

Article Review by Renee Ellis, Occupational Therapist, ASD Clinic

Rosenbaum, P. & Gorter, J. W. (2011). *The 'F-Words' in childhood disability: I swear this is how we should think! Child: Care, Health and Development, 38(4), 457–463.*

In this article, Rosenbaum and Gorter present a different approach to thinking about childhood disabilities. The 'F-words' they refer to are:

- Function
- Family
- Fun
- Fitness
- Friends
- Future

Their different approach offers new ways to make positive changes in the lives of children with disabilities, including ASD. In the article, the authors start by discussing some of the limitations we face in trying to 'fix' and 'treat' chronic childhood conditions. Using the World Health Organization's International classification of Functioning, Disability, and Health, Rosenbaum and Gorter have included these 'F-words' to re-frame how we look at disability.

Instead of starting with a disease, condition, or diagnosis, they suggest we start with looking at a broader context that reflects a dynamic system framework, including environmental factors, personal factors, activity, and participation. The authors suggest how the 'F-words' can be placed into the framework in order to broaden further our concept of disability. Change in one part of the system, such as 'fun', can result in changes in other parts of the system, such as 'family' and 'friends'.

This suggests new possibilities for intervention. For example, a clinician may be able to suggest new opportunities for 'Fun' leisure activities for a child, with accommodations or adaptations to enable the child to participate. By enabling the child to access new leisure activities, he may also become more physically active, leading to improvements in physical health. Another example would be when a family member supports a child to engage in new physical activities (Fitness), leading not only to improved physical fitness but also improvements in mood. Family members, professionals, educators, etc. would all benefit from reviewing this article and considering how the 'F-words' may change their attitudes and intervention targets.

P. Rosenbaum is from the *CanChild* Centre for Childhood Disability Research, McMaster University, Hamilton, ON, Canada.

J.W. Gorter is from the NetChild Network for Childhood Disability Research, Utrecht, the Netherlands.

For more information on this topic, consider:

Cross, A., Rosenbaum, P. Grahovac, D., Kay, D., & Gorter, J.W. (2015). Knowledge mobilization to spread awareness of the 'F-Words' in childhood disability: lessons from a family-researcher partnership. *Child: Care, Health and Development*, <http://dx.doi.org/10.1111/cch.12249>.

FROM THE ASD CONNECTOR ARCHIVES

JANUARY 2010 ASD CONNECTOR

- What is Communication?
- It's Not Over Until...Prompts Are Faded and Generalization Occurs
- Sensory Activities
- Evidence-Based Practice Guidelines for ASD

MAY 2010 ASD CONNECTOR

- "But He Doesn't Like Positives!"
- The Benefits of Being Neutral
- Coping Over Time
- Optimistic Parenting
- Form, Content, and Use of Communication

SEPTEMBER 2010 ASD CONNECTOR

- Problem Behaviour: How Our Hardwiring Plays a Part
- Nobody is at Fault
- How to Help a Child with ASD Better Understand
- Book Review: Self-Advocacy and Disclosure

JANUARY 2011 ASD CONNECTOR

- Augmentative Communication Supports for Individuals with ASD
- Flexing the 'Change Muscle'
- Meta-Analyses of Research Findings Can Help Guide Practice and Policy
- Six Books related to ASD

MAY 2011 ASD CONNECTOR

- The Relationship Between Language and Attention
- Getting Their Own Way
- Canadian Charter of Rights for Person with Autism
- Developmental Services Ontario

SEPTEMBER 2011 ASD CONNECTOR

- Present with the Boulder
- Research and Social Stories
- Needs to Learn
- Stress and Coping
- Transition to Adult Services
- ABA-Based Services And Supports

JANUARY 2012 ASD CONNECTOR

- Says Who? The Complexities of Communication
- Before and After Problem Behaviour
- Sibling Relationships

JUNE 2012 ASD CONNECTOR

- Say A Little, Convey A Lot
- Book Review: Functional Behavioral Diagnosis, Assessment, and Treatment
- "This is Your Captain...It is Time to Refuel"

CLICK ON THE EDITION TO ACCESS

OCTOBER 2012 ASD CONNECTOR

- A Question of Intentionality
- Keeping the Learning Momentum Going
- You and Your Child's Behaviour
- Registered Disability Savings Plan
- Agonizing over Acronyms

FEBRUARY 2013 ASD CONNECTOR

- What is ABA?
- PDD to ASD
- Clinical Expert Committee on Autism
- Bridging the Gap

JUNE 2013 ASD CONNECTOR

- The Challenge of Private Events
- Essential Prerequisites for Communication
- New ASD Diagnostic Criteria: DSM5

OCTOBER 2013 ASD CONNECTOR

- Russell Barkley's Theory of Impulse Control
- "But He Understands Everything I Say"
- Augmentative Communication Supports for Individuals with ASD
- Getting Their Own Way

MARCH 2014 ASD CONNECTOR

- A Review About the Hidden Curriculum
- Evidence-Based Practices
- Tricky Language
- "But He Doesn't Like Positives"
- Sibling Relationships

JULY 2014 ASD CONNECTOR

- The Lead Up to Eating
- Red Flags: When to Seek Help for Feeding/Swallowing Issues
- Connection Between Sensory Integration and Eating/Feeding
- "My Child Refuses to Eat Vegetables"

JULY 2014 ASD CONNECTOR

- Pharmacological Treatments for ASD
- Appreciation for Respite
- Reviews of Children's Books: "My Brother Sammy" and "Looking After Louie"

DECEMBER 2014 ASD CONNECTOR

- "Can Do or Not Can Do...That is the Question?"
- Just One Thing to Change
- When It's About 'Getting Stuff'
- Medications for the Treatment of Disruptive Behaviours in ASD

NEW BOOKS AT CPRI'S FAMILY RESOURCE CENTRE

By Mary Jane Venus
Community Behaviour Consultant, ASD Clinic

Middle School: The Stuff Nobody Tells You About

by Haley Moss

The transition to middle school for students with ASD can be a veritable minefield of hidden curriculum rules and social misunderstanding. Here, the author shares what worked and what didn't work for her to help others avoid some of the pitfalls of fitting in and doing well academically.



The Incredible 5-Point Scale

by Kari Dunn Buron and Mitzi Curtis

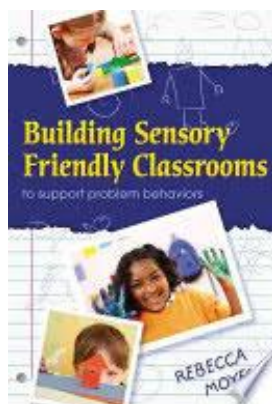
The significantly improved and expanded second edition for assisting students to understand social interactions and control their emotional responses.



Building Sensory Friendly Classrooms

by Rebecca Moyes

Lots of practical information and data driven strategies to support children with challenging behaviors.



Asperger's Rules! How to Make Sense of School and Friends

By Blythe Grossberg

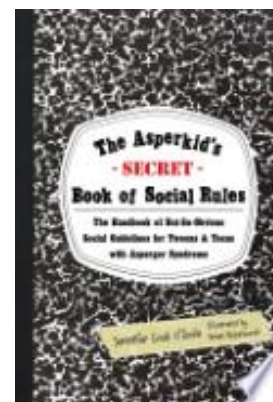
Packed full of information, this book covers common school situations and the uncommon challenges that they can present to a child with Aspergers. Kids will find the how-to for understanding and communicating with peers and teachers, standing up for and taking care of themselves, setting realistic goals, and making friends.



The Asperkid's Secret Book of Social Rules

by Jennifer Cook O'Toole

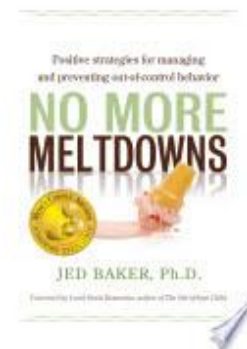
Written from the perspective of a tween or teens with asperger syndrome, this handbook provides an outline of the "not-so-obvious social guidelines" they often miss.



No More Meltdowns: Positive Strategies For Managing And Preventing Out-of-Control Behavior

by Jed Baker Ph.D.

Provides tools drawn from years of applied research on motivating children and managing challenging behaviour.

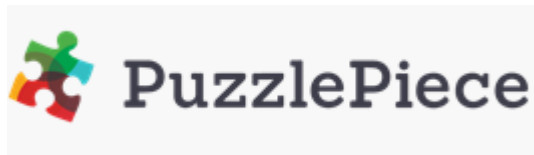


These books are available for loan at CPRI's Family Resource Centre (FRC) library located in the Crombie Building, first floor, beside the waiting room.

CHECK IT OUT



Click on the above image to find out about Aiden Lee, winner of the Autism Resource Kit Design Challenge and whose art is depicted on the cover of the MCYS Autism Parent Resource Kit.



After having 2 nephews diagnosed with ASD, Stephen Espinosa left Google to start Puzzle Piece, an organization that provides affordable tablets and apps for kids with autism. Click on the above image to read more.

Autism Center of Excellence

By clicking on the Autism Center of Excellence at Western Michigan University image above, you can access a series of free video interviews with national experts in applied behavior analysis, autism and behavioral pediatrics.

A Clinical Treatment Guide to
10 Common
Pediatric Behavioral Problems

Here, Dr Ennio Cipanni offers a free book to download that addresses ten common behavioural problems in children including eating problems, bedtime challenges, and car trips. Click on the above image and check it out!

BE NOTIFIED

To be notified when future editions of the ASD Connector become available, please **[add your email here.](#)**

The ASD Connector, including archived editions from 2010, is available at the website <http://www.cpri.ca/content/page.aspx?section=25>. Individual articles also are available at this link.

If there are topics you would like to see in future editions of the ASD Connector, let us know. Also, if you have an interesting family anecdote or written work/artwork that was completed by a person with ASD, please send them our way. Submit contributions for this next edition by November 15, 2015, by any of the following methods:

- ✂ give to any CPRI ASD Clinic team member
- ✂ send to: Patty Petersen, ASD Clinic, CPRI, 600 Sanatorium Road, London, ON, N6H 3W7
- ✂ fax to 519-858-3913 with attention to Patty Petersen, ASD Clinic
- ✂ e-mail to Patty.Petersen@ontario.ca or call 519-858-2774, extension 5522

*Newsletter content is for your information
Inclusion of websites, articles and viewpoints
does not imply endorsement
nor does exclusion indicate lack of
endorsement by CPRI*

CPRI EDUCATION EVENTS

Workshops & Training Courses

CPRI provides evidence-informed learning to support professional development. Internal, national and international expert speakers are hosted to facilitate professional learning and skill development. Workshops are held onsite at CPRI at Zarfes Hall (London, Ontario).

Webinars

Webinars are provided by CPRI staff on a variety of topics. Webinars are short online presentations that require you to have a computer and Internet connection to participate.

Clinical Presentations

Education and community capacity building is a significant component of CPRI's strategic direction. We provide a comprehensive list of topics available for presentation by CPRI staff. Advance notice is required and presentations are subject to availability.

CPRI Clinical Series

Each year, our clinical teams offer intensive educational series in an area of speciality taking place over several weeks. These series are offered (in person, and/or via OTN) as indicated in the listing.

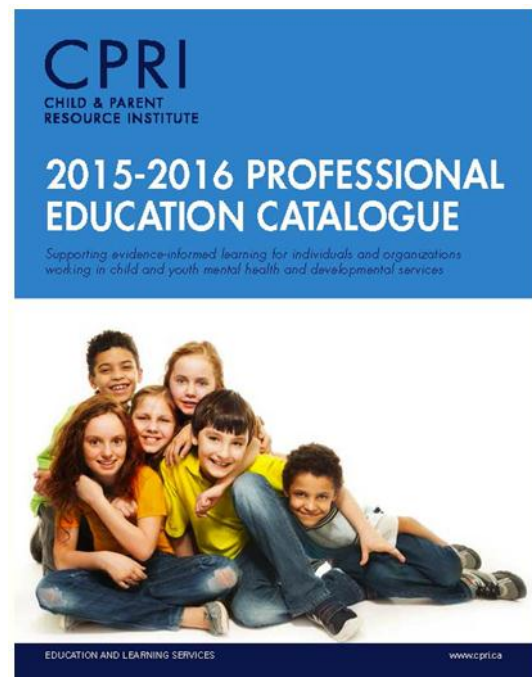
Videoconferencing

Workshops and training courses may be available using videoconference technology through the Ontario Telemedicine Network (OTN).

<https://otn.ca/en>

Registration Information

All of our events require registration, and some require payment. Click on the different offerings to find out how to register, or [see page 38 of the Catalogue](#).



2015 Fall Lecture Series | Autism Spectrum Disorder – Knowledge and Practice

A five week lecture series about the diagnosis of Autism Spectrum Disorder (ASD). Each week will offer information about a different clinical area, discussing symptoms and ideas to support individuals with ASD.

Presentations are intended for parents or family members, as well as front-line professionals (teachers, early childhood educators, developmental services workers), students, or anyone else with interest in this topic.

- 1** Tuesday, October 13, 2015
Diagnosis and Pharmaceutical Treatment for ASD
Presented by: Dr. Rob Nicolson, Psychiatrist

- 2** Tuesday, October 20, 2015
The Language and Social Communication of ASD
Presented by: Joan Gardiner and Mandy Harloff, Speech-Language Pathologists

- 3** Tuesday, October 27, 2015
Sensory Integration and ASD
Presented by: Lisa Hoyland, Occupational Therapist

- 4** Tuesday, November 3, 2015
The Link Between ASD and Problem Behaviour
Presented by: Patty Petersen, Board Certified Behaviour Analyst

- 5** Tuesday, November 10, 2015
Understanding ASD
Presented by: Dr. Craig Ross, Psychologist

Each weekly session will run from 6:30 – 8:30 p.m. in Zarfes Hall, CPRI (600 Sanatorium Road, London, Ontario, N6H 3W7). There is no cost to attend the workshops.

To register, please contact Jennifer Brown at (519) 858-2774, extension 5507 or by email at: Jennifer.Brown4@ontario.ca

Also, please note that you can register to attend via the Ontario Telemedicine Network (OTN). Again, please contact Jennifer Brown to make arrangements.