S I G N

PROPOSED REVIEW OF SIGN GUIDELINE CONSULTATION FORM

Title of guideline	SIGN 98: Assessment, diagnosis and clinical interventions for children and young people with autism spectrum disorders
Date of publication	July 2007
SIGN summary of the scoping search	**Guidelines** • Cincinnati Children's Hospital Medical Center. 2009. Best evidence statement (BESt). Outcomes assessment tool for children with autism spectrum disorder (ASD). Cincinnati (OH): Cincinnati Children's Hospital Medical Center. http://www.guideline.gov/content.aspx?id=15245 [Accessed 4/10/2010]. • Cincinnati Children's Hospital Medical Center. 2009. Best evidence statement (BESt). Use of motor and self-care assessment tools for children with autism spectrum disorder (ASD). Cincinnati (OH): Cincinnati Children's Hospital Medical Center. http://www.guideline.gov/content.aspx?id=15243 [Accessed 4/10/2010]. • Cincinnati Children's Hospital Medical Center. 2009.Best evidence statement (BESt). Use of sensory assessment tools with children diagnosed with autism spectrum disorder (ASD). Cincinnati (OH): Cincinnati Children's Hospital Medical Center. http://www.guideline.gov/content.aspx?id=15246 [Accessed 4/10/2010]. • Department of Health. 2010. Fulfilling and rewarding lives: the strategy for adults with autism in England. London, United Kingdom. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113369 [Accessed 1/10/2010]. • Department of Health. 2009. Services for adults with autistic spectrum conditions (ASC): good practice advice for primary care trust and local authority commissioners. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_097418. London, United Kingdom. [Accessed 1/10/2010] • Ministries of Health and Education. 2008. New Zealand autism spectrum disorder guideline. Wellington (New Zealand): Ministry of Health; Wellington, New Zealand. • http://www.moh.govt.nz/moh.nsf/indexmh/nz-asd-guideline-apr08 [accessed 1/10/2010]. **NOT YET published** • NICE. (September 2011 expected). Autism spectrum disorders in children and young people: recognition, referral and diagnosis. http://guidance.nice.org.uk/CG/Wave15/78 [Accessed1/10/2010]. • NICE. (to be confirmed). Autistic spectrum conditions: diagnosis and management of autistic spectrum conditions in adults http://guidance.nice.org.uk/CG/Wave23/1 [Accessed 1/10/2010]. **Cochrane Systematic Reviews** • Gold Christian, Wigram Tony, Elefant Cochavit. Music therapy for autistic spectrum disorder. Cochrane Database of Systematic Reviews: Reviews 2006 Issue 2 John Wiley & Sons, Ltd Chichester, UK DOI: 10.1002/14651858.CD004381.pub2(2). http://onlinelibrary.wiley.com/o/cochrane/clsysrev/articles/CD004381/frame.html • Jesner Ora S, Aref-Adib Mehrnoosh, Coren Esther. Risperidone for autism spectrum disorder. Cochrane Database of Systematic Reviews: Reviews 2007 Issue 1 John Wiley & Sons, Ltd Chichester, UK DOI: 10.1002/14651858.CD005040.pub2(1). http://onlinelibrary.wiley.com/o/cochrane/clsysrev/articles/CD005040/frame.html • Millward Claire, Ferriter Michael, Calver Sarah J, Connell-Jones Graham G. Gluten- and casein-free diets for autistic spectrum disorder. Cochrane Database of Systematic Reviews: Reviews 2008 Issue 2 John Wiley & Sons, Ltd Chichester, UK DOI: 10.1002/14651858.CD003498.pub3(2). http://onlinelibrary.wiley.com/o/cochrane/clsysrev/articles/CD003498/frame.html

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	• Stephenson, J. and M. Carter (2009). "The use of weighted vests with children with autism spectrum disorders and other disabilities." Journal of Autism and Developmental Disorders **39**(1): 105-114. http://www.springerlink.com/content/r070443852813491/fulltext.pdf • Walker, G. (2008). "Constant and progressive time delay procedures for teaching children with autism: a literature review (Structured abstract)." Journal of Autism and Developmental Disorders **38**(2): 261-275. http://www.springerlink.com/content/1682710076n68305/fulltext.pdf **RCTs** 55 RCTs were also identified
Main conclusions from new evidence	**Non-pharmacological interventions** • More research is needed to examine whether the effects of music therapy are enduring, and to investigate the effects of music therapy in typical clinical practice. • Behavioural or cognitive-behaviour therapy alone appears to be an effective treatment for OCD in children and adolescents. It is as effective as medication alone and may lead to better outcomes when combined with medication compared to medication alone. • Meta analyses suggest early intensive behavioural intervention is an effective treatment, on average, for children with autism supports. The clinical implication that at present it should be an intervention of choice for children with ASD. However, randomized controlled trials comparing EIBI to other interventions are still needed. • A review found very few good quality studies from which to draw conclusions about the effectiveness of parent-implemented early intervention. Both randomized and controlled studies tended to suggest that parent training leads to improved child communicative behaviour, increased maternal knowledge of autism, enhanced maternal communication style and parent child interaction, and reduced maternal depression. • A meta-analysis suggests that self-management interventions are an effective treatment for increasing the frequency of appropriate behaviour of students with autism. • Despite their widespread clinical use, empirical support for social skills training programs for children with Asperger's Syndrome or high-functioning autism is minimal • Constant (CTD) and progressive (PTD) time delay have been shown to be both effective and efficient for use with students with ASD. • There is inadequate evidence that applied behaviour intervention has better outcomes than standard care for children with autism. • While there is only a limited body of research and a number of methodological weaknesses, on balance, indications are that weighted vests are ineffective. • Evidence for efficacy of gluten and/or casein exclusion diets is poor. • There is currently insufficient scientific evidence to determine if omega-3 fatty acids are safe or effective for ASD. **Pharmacological interventions** • Risperidone given to children with autism at doses up to 3.5 mg for up to 8 weeks appears to have no detrimental effect on cognitive performance. • Combination of atypical antipsychotic medications and pentoxifylline or a glutamate agent such as piracetam might have synergistic effects in treatment of behavioural problems of children with autism. • Risperidone treatment was associated with two- to four-fold mean increases in serum prolactin in children with autism. • A child with ASD may benefit from a trial of naltrexone therapy, particularly if the child exhibits self-injurious behaviour and other attempted therapies have failed. Serious adverse effects have not been reported in short-term studies.

	• There is no evidence of effect of SSRIs in children and emerging evidence of harm. There is limited evidence of the effectiveness of SSRIs in adults from small studies in which risk of bias is unclear. • There is no evidence that single or multiple dose intravenous secretin is effective and as such it should not currently be recommended or administered as a treatment for autism.
New areas that could be added to the guideline	

Summary of the recommendations that could be updated	A The Lovaas programme should not be presented as an intervention that will lead to normal functioning. B Behavioural interventions should be considered to address a wide range of specific behaviours in children and young people with ASD, both to reduce symptom frequency and severity and to increase the development of adaptive skills.	Section: 5.3.1 5.3.2

Please answer the following questions as fully as possible:

Specialties:	Psychiatry (2), Lay representation (1), other (1)

1(a) Is there still a requirement for an evidence-based guideline on this topic?

Yes – 4

The Autism Strategy is the Scottish Government's key policy driver for ASD services over the next 10 years. A revised SIGN guideline that retains SIGN 98's optimality across all the domains of screening, assessment, clinical interventions, service models, recommendations for research and audit will be a crucial ingredient of, and point of reference for, the Autism Strategy.

In my opinion, SIGN 98 should absorb everything of relevance from the forthcoming NICE guideline on children and adolescents (and adults) and refer to that NICE work specifically as being optimal for UK as a whole. However, SIGN 98 should retain its UK optimality re everything that the NICE work specifically misses out and which SIGN 98 covered. The SIGN 98 revision group should be given a remit by SIGN council to suggest additional new areas for coverage, if the the revision group believes such new areas possess an evidence base or are of significant relevance, e.g. for implementation of the Autism Strategy and will consequently assist the Autism Strategy implementation.

SIGN 98 has provided a highly effective support for professionals working with ASD in Scotland and beyond. It has been converted into an e-CPD module, available to all worldwide. I believe that SIGN should aim to ensure that SIGN 98's high profile within the ARG work and therefore within the Scottish Government perspective on ASD, is maintained. In my opinion, a full review of the guideline, in the way that I have outlined, is essential for the success of such a process.

1(b) If no, should the guideline be withdrawn?

N/A

2(a) Based on the information given above, and your own clinical judgement, does the guideline require revision in the light of new evidence? *Please give details.*

Section 3.4 Biomedical investigation, Sections 5. non-pharmacological interventions, Section 5.3.1: There is emerging evidence supporting the use of early behavioural interventions and this section needs to be revised in light of this, Section 6 pharmacological side effects, slow reactions, Section 7 transition protocols, young people to adult reassessment, care plans and reviews 14 – 19 to include PSE gaps, co -morbid condition update or adding on, medication and MH medication reviews, 7.1 ASD Training, 7.2.3 Transitions, 7.3 Timing of interventions should be reviewed

2(b)	If no, is there a need to scope for new evidence on a yearly basis?
	No
2(c)	Do you agree with the assessment of the impact of the new evidence and its likely effect on recommendations?
	Broadly agree.
2(d)	If yes, please suggest clinical questions that could be addressed in the revision?
	Is there evidence to support universal provision of early behavioural interventions in children and young people diagnosed with autism spectrum disorders in clinical services?

3(a)	Please list any additions to the remit of the guideline that you think would be beneficial
	Sensory tools, adult support and protection. good PSE and transition protocols, good social work care review protocols to pick up PSE YP to adulthood gaps, sexual health and consent training and protection before they leave school, sleep management in YP, PSE and financial planning, service partnership around joint services/service changes. Adding a section on oral health highlighting the benefits of clinical prevention and good oral health promotion to prevent the need for treatment which normally involved general anaesthesia and hospital admission.
3(b)	Please list any sections of the guideline that are no longer required
	None

4	Please tick your preferred option for reviewing this guideline	
	a. there is no new evidence that will affect existing recommendations and the guideline should not be reviewed at this time	
	b. some recommendations will change in the light of the new evidence and elements of the guideline should be reviewed	✓

5 SIGN COUNCIL			Date: 11/11/2011
Revalidate	**Refresh**	**Revise**	**Remove**
	✓		