



CCJCRC@clermontcountyohio.gov



Clermont County
Juvenile
COMMUNITY RESOURCE CENTER

**2026 Juvenile Court /
Clermont County
School Summit –
A Brief Presentation
on Autism**

**“Lighting the
Way
to a
Brighter Day!”**

Go here for all Resource Center Information:

<https://clermontcountyohio.gov/clermont-county-jvenile-community-resource-center>

Mission

The CCJCRC strives to keep youth at home and out of the juvenile justice system, including out of detention. We do this by working collaboratively with each youth and their custodians, connecting them with support, treatment, and other services in the community.

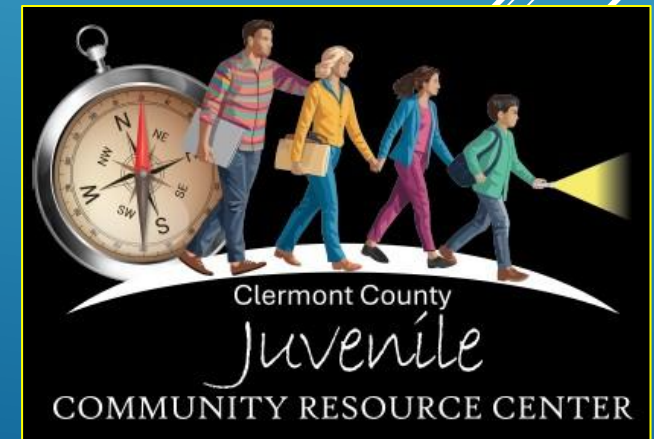
(All services are voluntary)

We also serve families who need help getting better resourced in our county.

(NOTE: The CCJCRC is not set up to be a crisis center for medical or mental health crises).

Primary Roles of the CCJCRC:

- 1) Working with families to help keep their child **out of Juvenile Court and out of the Detention Center**.
 - Includes use of several different assessment tools (see 2nd slide down)
- 2) Working with families to help **connect them** with vital resources in our county and sometimes online as well.



Our Staff:

Mike Rosser –
Program Manager,
Grant Writer

Greg Handleton –
Case Navigator,
Group Facilitator,
Assessor



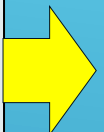
Susan Stark –
Mentoring Coordinator,
Case Navigator

Paige Olson –
CCJCRC Director

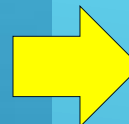
Hillary Adams –
Case Navigator,
Group Facilitator

Assessment Tools In Use:



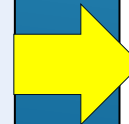
- 
- Grit
 - Hope
 - Leadership
 - Global Satisfaction
 - Personal Standards
 - Anxiety

- Depression
- Self-Criticism
- Ostracism
- Current Traumatic Stress
- Drug/Alcohol Concerns
- Relationship Discord



Plus, the parent gets a copy of the report emailed directly to them.

Massachusetts Youth Screening Instrument-Version 2 (MAYSI-2)



Answers provide scores on 7 scales:

- Alcohol/Drug Use
- Angry-Irritable
- Depressed-Anxious
- Somatic Complaints
- Suicide Ideation
- Thought Disturbance
- Traumatic Experiences

TSCC™

Trauma Symptom Checklist for Children™

Columbia-Suicide Severity Rating Scale (C-SSRS)

The Columbia-Suicide Severity Rating Scale (C-SSRS) is a unique suicide risk assessment tool that supports suicide risk assessment through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the person needs. Users of the C-SSRS tool ask people:

- Whether and when they have thought about suicide (ideation)
- What actions they have taken—and when—to prepare for suicide
- Whether and when they attempted suicide or began a suicide attempt that was either interrupted by another person or stopped of their own volition



ABOUT THE CRAFT

The CRAFT is a well-validated **substance use screening tool** for adolescents aged 12-21. It is recommended by the American Academy of Pediatrics' Bright Futures Guidelines for preventive care screenings and well-visits.

The PADDI-5 covers the following areas in accordance with the *DSM-5*:

- Substance use disorders
- Major depressive episodes
- Manic episodes
- Panic attacks
- PTSD
- ADHD
- Conduct disorder
- Oppositional defiant disorder



Also covered in the context of this 35-45 minute interview are:

- Dangerousness to self or others
- Victimization: physical, sexual and emotional abuse
- Symptoms indicative of psychosis
- Indications of phobias and generalized anxiety

Issues That May Prompt a Referral to the CCJCRC :

- Increasing concerns about truancy.
- The school would normally consider filing a charge with Juvenile Court in a particular case, but the child is quite young ... under the age of 9 or 10.
- A child needs the support of a mental health provider, no such provider is available at school, the family may struggle to access a therapist outside of school, and behaviors are getting worse.
- Behavioral problems at school that are likely to lead to expulsion if the next line is crossed (e.g., "Johnny hasn't actually hit anyone yet, but if/when he does ...").
- Recognizing that the family may be struggling to access resources and/or "stay afloat" without help.

CCJCRC Groups



All About Being A Teen



- Week 1: Nurturing yourself
- Week 2: Personal Power
- Week 3: Positive Communication
- Week 4: Anger Management
- Week 5: Hope, dreams, and goal setting
- Week 6: Staying safe (drugs, peer pressure, bullying, etc.)
- Week 7: Family night

When: Mondays
5:00-6:30

Where: Juvenile Community
Resource Center
2339 Clermont Center Drive

7 WEEK empowerment group designed to help teens build confidence, emotional awareness, communication skills, and healthy decision-making habits. Each week focuses on a core life skill that supports personal growth, resilience, and safety.



This group
DOES run
through
the school
year;
referrals
are always
being
accepted.



Coffee Talk

A support and resourcing
group for custodial
grandparents

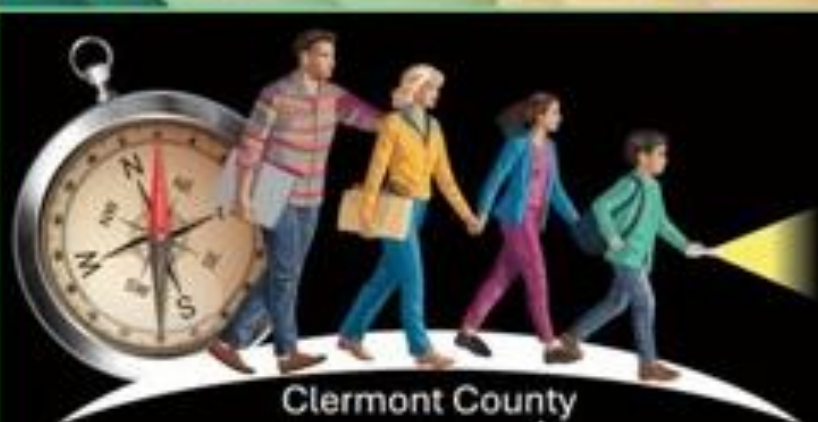
FREE!

Dates: Wednesdays
(ongoing)

Location: 2339 Clermont
Center Dr. - Batavia, OH
- 45103

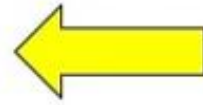
Time: 11:00 - 12:00 PM

RSVP to: Paige Olson:
513.732.7697 (office)
[polson@clermontcountyohio](mailto:polson@clermontcountyohio.gov)
[.gov](mailto:polson@clermontcountyohio.gov)

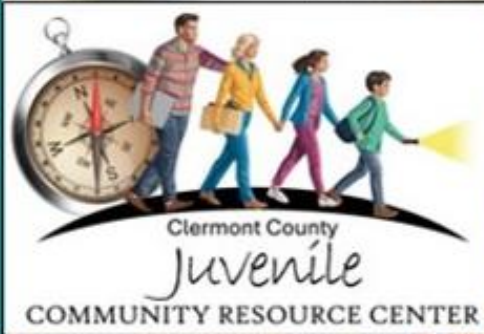


Clermont County
Juvenile
COMMUNITY RESOURCE CENTER

L.I.F.E SKILLS GROUP



(See <https://clermontcountyohio.gov/clermont-county-juvenile-community-resource-center/> for more info)



Week 1: Social
Connections, Goal
Setting

Week 2:
Communication

Week 3: Driver's
License and
Substance Use

Week 4: Career
Preparation

Week 5: Financial

Week 6: Housing
and Cooking/ Meal
Planning

Week 7: Safe
relationships

*(This group is NOT for
court-involved teens!)*

WHEN: Starting June 4th - July 16th

Thursdays 1:00-2:30

WHERE: Community Resource Center

2339 Clermont Center Drive
Batavia, OH 45103

CONTACT Hillary Adams to RSVP

513-732-7808 or email hadams@clermontcountyohio.gov

FREE!

Ages 16 - 18

This group was
run twice
during summer
break and is
expected to
return to our
schedule next
May.

A Networking Group for Parents of Autistic, AD/HD, & Other Neurodivergent Kids

FREE!



Clermont County
Juvenile
COMMUNITY RESOURCE CENTER

Dates: Every Tuesday evening
from 6:00-7:30, starting 4/28/26.

Location: 2339 Clermont
Center Dr., Batavia OH, 45103.

Parking: At front and on side of
building, or across the street.

(Childcare is not available at this time)

Autism Curriculum “Chapters” (PDFs) Available Via the CCJCRC Webpage:

- Note: These are regularly edited, added to, and refined:

- [Autism Class Introduction](#)
- Autism Causes & Traits & Definitions
- Autism & Gut Health & Detoxing
- Autism & Trauma
- Autism Assessments & Treatments & Interventions
- Autism Products & Resources
- Autism Success Stories
- Foundations For Parenting All Children
- Leveraging Autistic Kids Strengths & Interests
- Reducing or Eliminating Autism Symptoms

The following slides are being offered in acknowledgment that **most teachers have Autistic kids in their classrooms**, specifically those that have **not (yet) met criteria for services** through the Developmental Disabilities Board in our county. In other words, **YOU'RE ALREADY DEALING WITH THEM** since **1 in 31** are diagnosable ... and that number is as high as **1 in 20** amongst males.

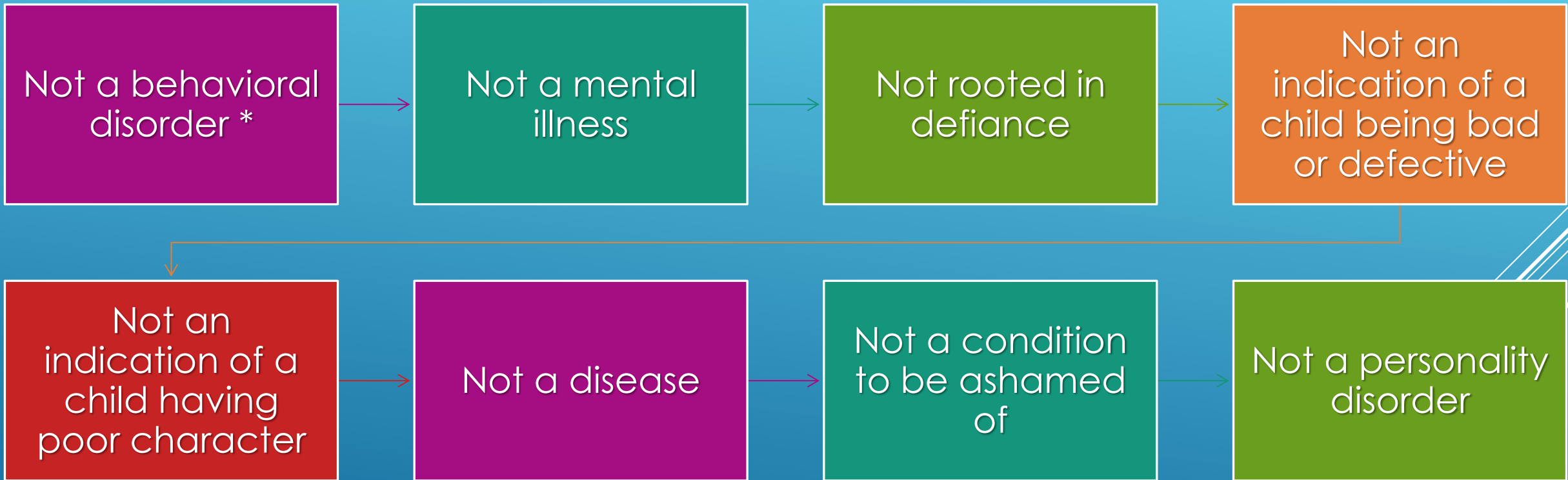
HOW TO KNOW IF A STUDENT MIGHT BE AUTISTIC OR HAVE AUTISTIC TRAITS

*“If you’ve met one person with Autism,
you’ve met one person with Autism” –*

Dr. Temple Grandin

WHAT **ASD** IS NOT:

From a video by Tom Galperin, founder of Galperin Autism Consulting LLC



Not a
condition
they will
“outgrow”

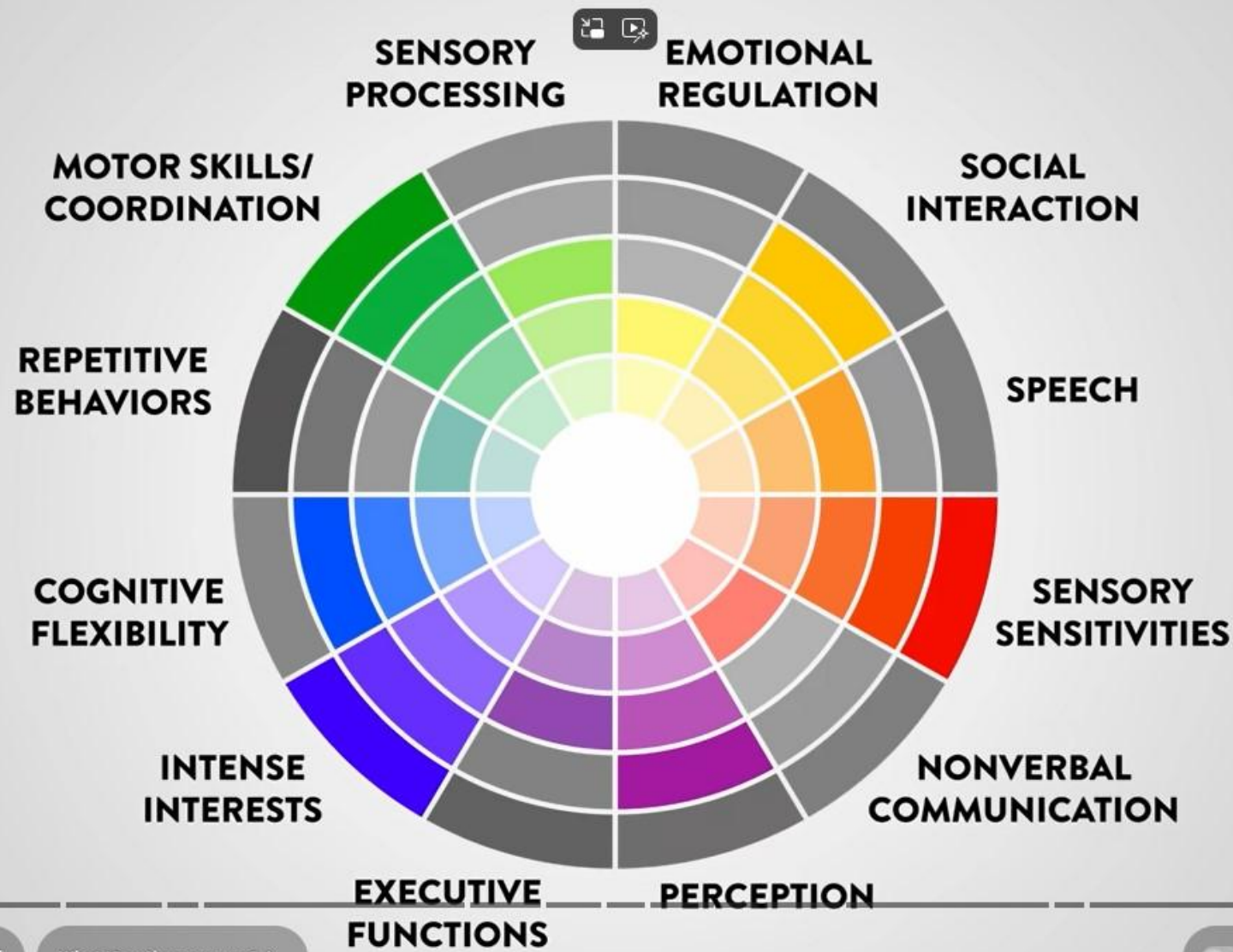
When Diagnosing Autism:

Specify

- With or without intellectual impairment
- With or without language impairment
- Associated with another neurodevelopmental, mental, or behavioral problem
- With catatonia
- Associated with a known medical or genetic condition or environmental factor

Levels

3. "Requiring very substantial support"
2. "Requiring substantial support"
1. "Requiring support"



3:11 / 36:47

What IS autism anyway? >

The more pie-wedges that are lit up with color, the more that area of functioning is present and is a part of the Autistic person's set of **assets** or **deficits**.



#AutismAwarenessMonth

HHS.gov

From a Webinar by Dr. Wes Dotson entitled, **What Criminal Justice Professionals Need to Understand About ASD** (provided through Justice Clearinghouse):

Markers that you might be talking to somebody who's on the spectrum.

- Struggle with eye contact
 - Might be looking at something else other than your eyes
 - Might be staring at you and never breaking eye contact
- Repetitive behaviors or pacing
 - When overwhelmed or in a situation or environment for which they don't have any history or expectations, repetitive behaviors are amplified
 - E.g., Pacing, flapping hands, rocking, looking at hands
- Unusual or no response to spoken instructions
 - They do not respond to spoken instructions from someone they don't know in an environment in which they're not familiar
 - When they are overwhelmed, they're not processing language well
 - If you're encountering someone with autism in public for the first time, they're probably not going to respond at all
 - The more you talk to try to make them respond, the less likely they are to respond because they get overwhelmed by the language

CHARACTERISTIC BEHAVIORS THAT CAUSE PROBLEMS (42:05)

Literal

- They struggle to identify non-verbal cues
 - They are black and white
 - They're going to take what you say and only what you say and respond to that
 - They interpret language based only on its literal meaning
- They're usually not being difficult or defiant
 - ✍ Go play outside
 - Mom who asked a child who is preoccupied with computer games to go outside went and played his computer game outside
- Be aware of your language and explain exactly what you want and be prepared to clarify

☞ Boil 2 cups of water

- Instead of measuring 2 cups of water and putting it in a pot to be boiled, he put water in two cups and boiled it

- When you mention that what they did – following your instruction – was wrong, it will confuse them because they just did what you said

- They will do exactly what you said – not what you meant, wanted, wished, or intended

- It's not coming from a place of disrespect

- They are sincerely trying to do exactly what you say

- Instead of getting frustrated about them not doing what you said, think about what you said and what you meant

- The more stressed they are, the harder it is for them to process language

- It is not **just** a choice, and they can't just listen, focus harder, or pay more attention, it's just that's not how their brains work

Repetitive and routine driven

- Difficulty handling surprises and changes in routines
 - They like things to be the same way all the time and they want a very consistent routine
 - They're going to have a lot more stress and a lot more anxiety when they're having to do something that they've never done before or is interrupting their daily routines
 - Those changes in routines could be in the form of a court hearing, traffic stop, wreck, meeting with a parole officer, or anything that is not a day-to-day routine activity
 - It doesn't mean that they're going to be angry or upset, but they're just going to be a little bit stressed or nervous than maybe might be warranted by what the conversation
 - You will likely encounter them already in a heightened state because whatever the situation, it is likely surprising or different

calls for

- Unusual sensory responses
 - People with ASD may respond in unusual ways to the environment
 - Not respond to loud noises or other people
 - Show increased sensitivity to things such as light level, crowds, sounds, and textures
 - Look for that and try to accommodate it as much as possible
 - Motor behavior is often unusual and persistent (spinning, tapping hard surfaces, pacing, rocking, flapping)
 - The more stressed they are, the more they tend to engage in repetitive behaviors, and the calmer they are, the more of those behaviors tend to come down.
 - The rate of repetitive behavior can be a useful barometer
 - The more escalated they are, the more we need to talk less, give them space, simplify things
 - When the repetitive behavior gets less, we can start using a little more language, and interacting a little bit more
 - What these characteristics mean for you
 - When you interact with people with autism, they will struggle more as more people are around
 - The fewer people and stuff going on – the better they're able to focus

- They will engage in more unusual social behavior (especially when stressed) – it WILL be awkward
- People with autism often get overwhelmed
 - People with autism have a threshold **that is a lot lower than that experienced by neurotypical people**
 - When the environment is too much and they can't process anymore, they're not going to be able to interact with you or successfully navigate the environment until they've had a chance to calm down
 - Give them the space and the time to calm down before you try to move interactions forward

- Overwhelm/sensory overload looks like
 - Rocking
 - Covering their ears
 - Physically running away
 - Resisting physical contact
 - Stopping from speaking
 - Curling into a ball and going to a corner
 - Zoning out
 - Pacing
 - Screaming
 - Irrate repetitive behaviors

• **Difficulty Communicating:**

- **They struggle with communication when they're calm, so ... when stressed?**
- **If feelings of overwhelm are present:**
 - Likely to not respond to spoken language; Less likely to “get” non-verbal cues/body lang.
 - WILL respond in unusual or what neurotypicals would label as “excessive” ways.
- **Assume non-responsiveness is passive (non-willful) failure to perceive expectations RATHER than active resistance, defiance, or low motivation.**
 - They are not choosing to fail to meet your expectations.
 - When overwhelmed, they often don't even recognize other people and/or what is being asked of or demanded from them.
- **The more you talk and the more you try to exercise power and control, the harder it becomes for them to process and comply.**
 - You are not going to be able to “talk them down.”
 - The more they have to keep trying to pay attention to your language, the more overwhelmed they become.
 - Often de-escalation with an ASD individual looks like giving them silence and space.
 - An Autistic adult in the community who's feeling dysregulated will know what they need to calm themselves down, which looks weird to others.

Why This Is Important:

News headlines sometimes reflect the drama of incidents where the Autistic person:

- Was trying to calm themselves down through stimming behaviors and they're perceived as being drunk, on drugs, or being wildly defiant.
- Was engaging in self-soothing behaviors while driving or while they are in a public place, bystanders assume impairment, someone calls 911, and the situation escalates from there.

Because the ASD person is stressed, therefore they are not able to tune-in to others' words, therefore they end up being "non-compliant" with the officer, they get arrested, and the Autistic person doesn't understand what they did wrong.

And so, if attention is taken-over by whatever occupies it ...

**and spare attention isn't available,
it's very difficult to cope with change of expectation,
new circumstances, or recognize sensory,
interoceptive messages or mood changes etc.**

**If an individual doesn't know what is happening to them
or can't explain it to another, their anxiety, frustration,
sadness, anger and so on, may show in behaviour.**

things

**Having such [^]recognized and attended to makes the
difference between developing mental health issues or a
sense of feeling valued.**

Separating Complex Autism Characteristics From Mental Ill-Health

By Dr. Wenn Lawson (pHd) AFBPs MAPs



**Certified Autism Spectrum Disorder Clinical
Specialist Intensive Training (ASDCS)–2nd Edition**

Per **Dr. Stephen Porges** (founder of Polyvagal Theory), all of these “symptoms” of ASD are **actually symptoms of an Autonomic Nervous System that is in a constant state of defense and self-preservation** due to **sensory overload** as well as **interoceptive signals** [of danger] from within ... creating a **negative feedback loop** that is difficult for the individual to break out of on their own.

Autistic Catatonia

A regression in self-care, functional skills and independence compared to previous levels.

A marked and obvious deterioration in:

- movement
- volition
- level of activity
- speech

Wing, L & Shah, A (2000) Catatonia in autistic spectrum disorders. British Journal of Psychiatry. Vol. 176, 357-362.

Wing, L & Shah, A (2006) A Systematic Examination of Catatonia-Like Clinical Pictures in Autistic Spectrum Disorders. Catatonia in Autism Spectrum Disorders. International Review of Neurobiology Vol 72 P.21-37. Elsevier Inc. USA.

Indicators include...

- increased slowness
- getting stuck in postures.
- freezing during actions
- increase in repetitive movements and hesitations
- difficulty starting & stopping actions
- difficulty completing movements
- increased reliance on physical or verbal prompts
- increase in repetitive and ritualistic behaviors
- difficulty crossing thresholds
- marked reduction in speech or complete mutism

“A lot of studies correlate IQ score [with] executive function. Barkley and others **demonstrate [that] that’s** not the case; [these two things are] not really correlated. I have this kid with Autism that I see who can build a car engine. He is seven. He can put together a car engine, but he can’t regulate his fists. We must **STOP making these kinds of assumptions based solely on IQ** “... if [they had followed] the traditional model in Education that IQ predicts executive functioning skills, [they would have] been **wrong** and this kid probably would never have reentered public school.” - Dr. Sean Ibermetzin

Separating



from
Executive
Function

Is Autism a:

- Behavioral disorder? - (learned and conditioned?)
- Neurobehavioral disorder? - (hard-wired disease?)
- Neurodevelopmental difference? - (differences in hard-wiring?)
- Other? – (problems with gut health, inability to metabolize folic acid?)

The “right” answer is:

1) It's a Neurodevelopmental **Difference**

And yet, clinicians adhering to the DSM 5 will refer to it accordingly as a Neurodevelopmental **Disorder**.

2) It's a sensory-motor-processing **challenge**

From “Spellers – The Movie” (a documentary on Autism – see later slides). Yes, there are social **deficits** involved, but that's not what ASD **is**.

Sensory

My sensory sensitivities are more than just a dislike or a preference.

They are more than a nuisance or something I can tune out or get used to.

They are often disorienting, very **painful**, disabling, and isolative.

They make it hard to coordinate my body and make carrying out daily tasks and communications exhausting, or sometimes just impossible.



Kim Clairy MS, OT

Regarding Autism, we must always strive to understand, “*What is the **FUNCTION** of the (violent or other) behavior?*” Here are some possible functions, most of which are also common to the human condition:

- ❑ **Attention-Seeking** (when “acceptable” or positive methods don’t succeed).
 - Remember, for all children, getting negative attention is better than getting none at all.
- ❑ **Expressing Pain or Discomfort**
- ❑ **Communicating Overwhelm**
- ❑ **Seeking Help**
- ❑ **Expressing Unmet Emotional Needs**
- ❑ **Escape or Avoidance** (removing themselves from an unwanted task, environment, or person ... or demands/expectations being placed on them)

The “Big Four”:

- 1) Escape/Avoidance
- 2) Attention
- 3) Tangible Gain(s)
- 4) Sensory/Autonomic

❑ Seeking Predictability (disruptive acts force adults to stop, slow down, and/or reset routines; ASD kids may use behavior to regain structure)

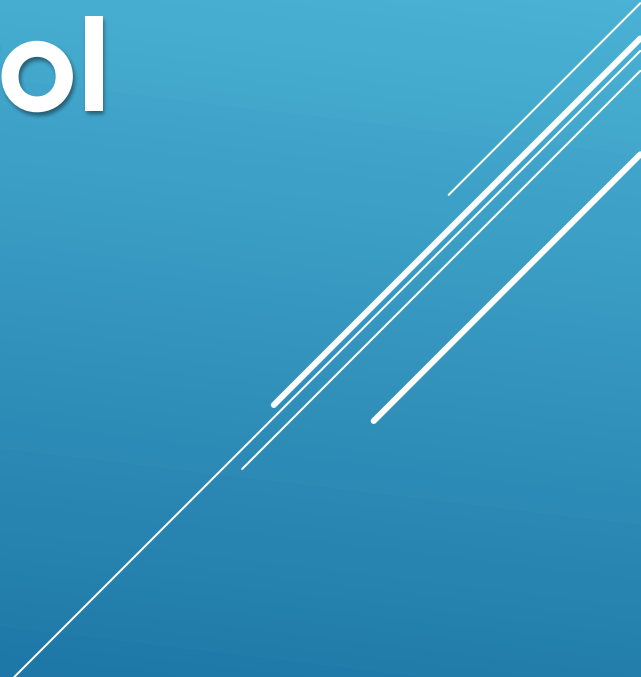
❑ Exerting Autonomy or Control

❑ Self-Advocacy

❑ Testing Boundaries

❑ Sensation-Seeking

❑ Sensation-Avoidance



- ❑ **Physical Release** (discharging built-up energy, restlessness, or hyperarousal – meltdowns can serve as a type of neurological reset in both neurotypical and ASD children)
- ❑ **An Attempt at Self-Regulation** (paradoxically using aggression or disruption to regain inner equilibrium)
- ❑ **Expression of Hunger, Fatigue, or Physiological Needs** (acting-out when basic needs aren't met; in ASD children, interoception challenges may mean that the child doesn't even recognize hunger, tiredness, etc., until sensations “boil over” through some kind of behavior)
- ❑ **Imitation of Observed Behavior**
- ❑ **Peer Influence or Social Gain**
- ❑ **Revenge or Retaliation**
- ❑ **Avoiding Social Interaction** (using behavior to push others away when interaction feels confusing, uncomfortable, draining, unsafe, or overwhelming; think about how many times a neurotypical child will avoid, for example, the uncomfortableness of meeting a new adult, etc.)
- ❑ **Protective Behavior**

**THOUGHTS ABOUT
HOW TO WORK WITH
AUTISTIC PEOPLE:
THE HELPER'S ATTITUDE
& BEHAVIORS**

Three white diagonal lines of varying lengths and thicknesses are positioned on the right side of the image, extending from the middle towards the bottom right corner.

How I imagined myself as a Teacher...



How I feel as a Teacher...



Being a teacher today, at any grade level, is A LOT! Please know that this presentation is not meant to “add one more thing” to your multiple, spinning plates! Still ... knowledge is power, and therefore it is hoped that this information will only serve to equip you in ways that will cut down from, and not add to, your own stress level.

What Should I Call You?

Person-First Language: “A person with Autism.”

Identity-First Language: “An Autistic person.”

- As a therapist I was always in the habit of saying, “A person with Bipolar Disorder” as a way of separating their built-in human worth from the negative stigma of their mental illness; but since Autism is not something that a person “**has**” but instead reflects a core aspect of who they **are**, many Autistic people now prefer Identity-First Language.

- <https://www.autisticscholar.com/84-2/>

We can measure a person's Way of Knowing, as well as their Way of Doing, but the problem with "old-school" treatment goals is that clinicians have worked for decades to try to change an Autistic person's ...

Way of Being! – to try to make them "normal"!

Not only is a person's Way of Being more difficult to define and remains rather abstract when trying to observe and measure it, but ... how much damage has been done in the name of "therapy" as doctors have tried to actually change an ASD person's Way of Being? A doctor, therapist, teacher, parent, bus driver, or cafeteria aid either *works with* or *tries to fix* ... one or the other!

(Jeffrey Guenzel MA, LPC, and Emile Gouws PhD)

Examples of Dysfunctional & Non-Helpful Statements:

(Kim Clairy MS, OT – Autistic adult)

WHAT HEALTHCARE PROFESSIONALS HAVE TOLD ME...

“Your Autism is moderate to severe...you belong in a nursing home”

“You’re oppositional”

“You’re being defiant”

“You have a personality disorder-OCD, schizoid, borderline ... (when I didn’t)”

“You’re manipulative”

“You’re non-compliant”

“You are not trying”

“You’re SELFISH”

“You are just doing it for attention (meltdowns)”



From a
Webinar by Dr.
Wes Dotson
entitled, **What
Criminal
Justice
Professionals
Need to
Understand
About ASD**
(provided
through Justice
Clearinghouse)

Keep in mind

- Don't take it personally
 - They're going to do things that feel off-putting or rude – they don't mean it, it's not personal, it's not aimed at you
- They usually WANT to do the right thing
- They LIKE rules and structure
 - People with autism like rules, consistency, stability, and predictability, and are often incredibly motivated to do the right thing
 - They tend to be the most compliant people once they understand what you want – they're rule followers
 - But if those rules and structures are not spoken or made explicit, they may not pick it up
- It will be awkward
 - They can't just turn it off, and focus and try a little harder
 - Their deficit is about how their brain is wired, not about a choice they're making to be rude or not do what you want

From a Webinar
by Dr. Wes
Dotson entitled,
**What
Criminal
Justice
Professionals
Need to
Understand
About ASD**
(provided
through Justice
Clearinghouse):

WHAT TO DO IF THEY'RE ESCALATED? (57:31)

- If possible, ignore the repetitive behaviors
 - Let them do that because that's often a coping mechanism.
 - Attempting to block or stop that repetitive behavior is going to escalate the situation
 - They're not going to respond well to that
 - If they're doing it in an unsafe place or you can't ignore it
 - Define for them a space, a safe place to do it
 - Redirect them to an empty part of a room, or a safe open space
- Simplify their environment as much as possible
 - Turn off sirens and lights
 - Have fewer people around
 - Ideally, bring in someone they know
 - The most direct way to help someone with autism
 - Having someone who knows them and their specific sensory sensitivities, language processing difficulties
 - Can often help simplify their environment to have a person with whom they do have routines and rules

- Give them silence unless they request an interaction
 - That's going to help calm them
- Talk and touch usually make it worse at the moment
 - The more we touch when someone with autism who is upset, the worse it's going to be in a moment because we're hitting them with language and sensory input at a time that they're already overwhelmed
- If you must talk –keep it simple and literal with time to process between remarks
 - One remark every 10 to 15 seconds to give them time to process especially when they're overwhelmed.
- Tell them WHAT to do vs. what NOT to do
- Even better –SHOW THEM what you want
 - Model, draw a picture, point, etc.
 - Because they may not hear language well
- Give advance notice when something is about to happen
 - Minimize surprises
 - Tell them as much as possible in advance
 - E.g., "Paramedics will come," "The police officer is going to be here in five minutes and he's going to do this"

From a Webinar by Dr. Wes Dotson entitled, **What Criminal Justice Professionals Need to Understand About ASD** (provided through Justice Clearinghouse):

What do we teach families and individuals with ASD?

- Families
 - Identify yourself and your family in advance
 - Register their house with dispatch or the emergency responding services to flag that there is a person with autism there
 - Provide a clear signal
 - A seatbelt band, wristwatch, sticker, etc. for first responders to know
- Individuals
 - Disclose as soon as possible
 - They're reluctant to say that they have autism because they're usually bullied or made fun of for that
 - Explain that interacting with justice professionals is one of those situations where it's better to say it and let them know you have autism so they may accommodate your potential needs to have a different, safer environment
 - Carry a card or some means of non-verbal communication
 - Something they can hand over or hold up for someone to see
 - Law enforcement, responders, advocates must be aware of this to facilitate that interaction
- For both: Make it as specific as possible

- Predictability and stability are important
 - Help them see how, whatever your interaction is, the conversation can follow a standard format
 - Provide visual support
 - Show them what will happen → "now, then, later"
 - Model or use pictures if possible → Use of strong interests to develop visual timelines, schedules, etc.
 - Give advance notice
 - Provide advance warning and instructions
 - Tell them before you touch them
 - Let them know what will happen and when as much as possible
 - Interactions get a lot easier when they have time to see things coming and anticipate

Ask what they need prior to each transition or new expectation.

There are several different kinds of “meltdowns” that ASD kids can and do experience:

- 1) Executive Function Meltdowns
- 2) Sensory Overload Meltdowns
- 3) Transition Meltdowns
- 4) Social Overwhelm Meltdowns
- 5) Emotional Flooding Meltdowns
- 6) Neurological Pain Meltdowns

Meltdowns (by Dr. Mark Bowers): “Once a child’s nervous system is fully activated, logic, lessons, and control are no longer available. And yet, this is the moment that parents are often told to fix it, de-escalate it, or make it stop. Here’s the issue: When a brain is in **full survival mode**, intervention can actually prolong the storm [through the use of] too many words, too much direction, [too many demands, and] too much urgency [which] keeps the nervous system running hot. So, here’s what we can do:

- First, recognize when regulation is no longer possible. Your job shifts from stopping the reaction to keeping everyone and everything safe.
- Reduce input: Fewer words, slower movements, neutral tone, [and ‘soft’ eyes].
- Allow the wave to crest and fall [or ‘come to shore’ naturally].

Holding the space means changing your role. You’re no longer the **Fixer**, you’re the **Anchor**. Your first job is to regulate *your* body, slow *your* breathing, lower *your* voice, and soften *your* face. A calm nervous system is contagious” ... and NECESSARY.

- Next, reduce stimulation without disappearing. Stand nearby but don't crowd. Fewer words are better than better words: No lessons, no logic, and no negotiating. If your child needs reassurance, use short and predictable phrases, like, "I'm here," "you're safe," and "this will pass." Then PAUSE.

Your goal is safety [and non-coercive de-escalation], not compliance. Move objects if needed. Create space.

Protect bodies, not rules. And remember, big emotions burn off faster when they're not being fought. In the moment, **your [calm and supportive] presence IS the intervention.**

The Traditional Goals of ASD Treatment & Hands-On Interventions Are Based on Outdated Models of Psychiatry:

- Trying to make an ASD person “normal.”
- IEPs are extremely deficits-based, which means that everyone on the team focuses primarily on deficits, with strengths and interests sometimes being an after-thought.
- Demanding that kids spend their time being focused only on their deficits in order to “work on them” IN ISOLATION from their strengths and interests ... and sometimes from warm, supportive, and meaningful support.
- Working on controlling and containing “undesired” behaviors.
- Demanding eye contact be initiated and maintained (which is not clinically drive but is simply a cultural preference).

Proper Goals in Working with ASD Clients:

- 1) **Avoid** goals and objectives driven by the expectation that an ASD client be “helped” to become more like neurotypical people.
- 2) **Communication** goals must be based on where the client is at developmentally as well as on how that person is *already* trying to communicate, even if non-verbally.
- 3) **Strength-Based**: No one, not even non-Autistic people, grow and develop by focusing solely on deficits/weaknesses; therefore, interactions must focus on identifying strengths and interests, and then leveraging those strengths and interests in various situations.
- 4) **Measuring Outcomes**: Make sure that outcomes are realistic. Again, is a neurotypical outcome of increasing eye-contact even meaningful or relevant in the first place?

The New Goals of ASD Treatment Based on Our New Understanding of Neurodiversity:

- Not to make the person not have ASD, but to help them function *with* their Autism. In other words, help them to become the most highly functioning Autistic person that they can be vs. trying to turn them into a poor imitation of a neurotypical person.
- Deficits need to be overcome with strengths-based strategies.
- Looking at ASD as a Neurobehavioral Disorder (per DSM 5) imposes certain behavioral EXPECTATIONS on the child, which then leads to CORRECTION, which leads to MELTDOWNS. The way around this is to **stop focusing on correction** and to **start focusing on strengths/interests** even as you continue to better understand the “why” behind certain “disordered” behaviors.

Even Though Even “Mild” Autism Can Be Quite Challenging, In-Classroom Interventions Are Still Available:

For example, one mother of an 8th grade Autistic boy still being maintained in a regular classroom setting explained the following:

- “When ‘John’ starts to get dysregulated in class, instead of the teacher embarrassing him by singling him out and stating aloud in front of other students that he needs to take his ‘Stimulation Break,’ all they need to do is stick a handwritten note in a folder for John to take to the school secretary, and then by the time he gets back to class, he’s regulated and no longer hyper-fixated on whatever was bothering him before. If the teacher thinks that’s a waste of time, well, if they don’t use this kind of intervention, the whole rest of John’s class time is going to be wasted in a fruitless struggle.”

The problem is that teachers sometimes hesitate to implement these kinds of strategies because these things are seen as being ‘**special treatment**.’ This is understandable. However, the thing is: Isn’t ANY strategy that’s being used with ANY kid basically ‘**special treatment**’ in one way or another?

Q

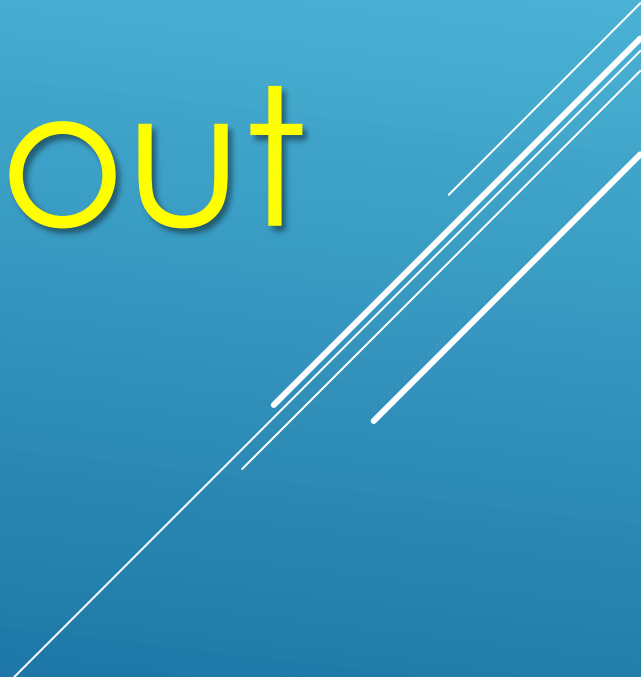
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Resources

(See paper handout
as well)

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LIVES in the BALANCE



EDUCATORS & SCHOOLS

Improving school culture, climate, and discipline means replacing punitive, exclusionary practices with a more compassionate, effective approach.



<https://livesinthebalance.org/educators-tour/>



WHERE COMPASSION AND SCIENCE INTERSECT

Collaborative & Proactive Solutions (CPS) is the evidence-based, trauma-informed, neurodiversity affirming model of care that helps caregivers focus on identifying the problems that are causing concerning behaviors in kids and solving those problems collaboratively and proactively. The model is a departure from approaches emphasizing the use of consequences to modify concerning behaviors. In families, general and special education schools, inpatient psychiatry units, and residential and juvenile detention facilities, the CPS model has a track record of dramatically improving behavior and dramatically reducing or eliminating discipline referrals, detentions, suspensions, restraints, and seclusions. The CPS model is non-punitive, non-exclusionary, trauma-informed, transdiagnostic, and transcultural.

And this website is the hub of free resources on the CPS model.



Solving Problems Rather Than
Modifying Behavior



Solving Problems Collaboratively
Rather Than Unilaterally

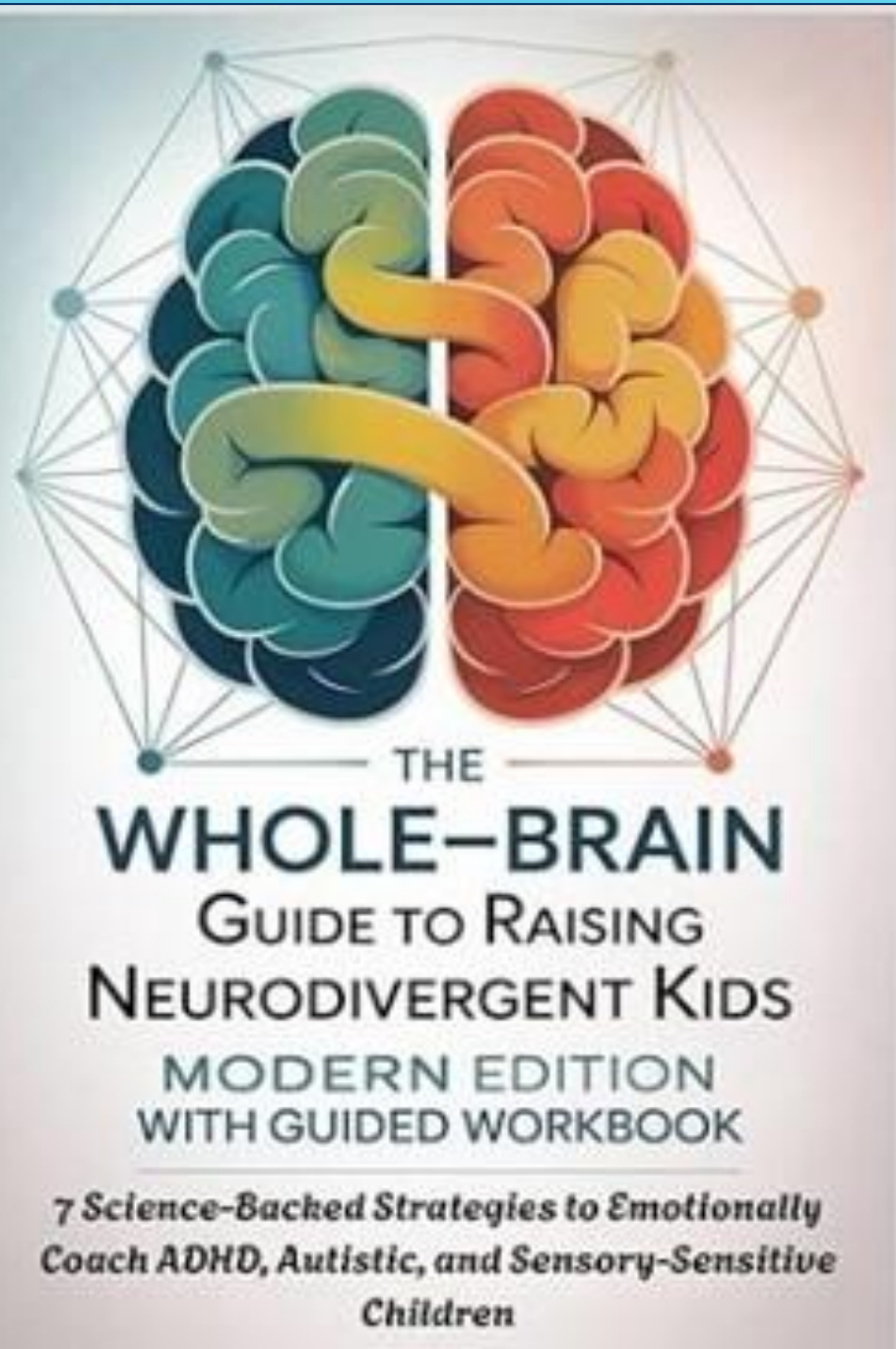


Let's Get You Out of the Heat of the
Moment



Kids Do Well if They Can

27 minutes
of teaching
that will
change
your life ...



They offer free email support for parents:

- EmergenceInstitute1@gmail.com

This would be an EXCELLENT book for teachers to read as part of their own efforts to better understand Autism in the context of a modern support model.

Ohio's Parent Guide to Autism Spectrum Disorder

This manual provides an overview of the world of autism spectrum disorders (ASD). It was developed by Ohio parents of individuals with ASD who have a broad range of experience with interventions, resources, and services. The group's work began with the question: *What do you wish you had known the first year your child was diagnosed?* The manual covers a wide range of topics of interest to families, and each chapter contains rich reference materials, including books, websites, and names of organizations where additional information on each topic may be obtained.

[Download the full Ohio's Parent Guide to ASD \(PDF\)](#)

Chapters

- [Introduction](#)
- [What is an Autism Spectrum Disorder?](#)
- [Screening and Diagnosis](#)
- [Living with ASD](#)
- [Interventions](#)
- [Accessing Educational Services](#)
- [Social Service Programs](#)
- [Advocacy and Disability Awareness](#)
- [Future Planning](#)
- [Definition of Autism Spectrum Disorder](#)
- [Useful Forms](#)
- [Navigating the Rough Waters](#)
- [Letter to Request a Multi-Factored Evaluation](#)
- [Process for Determining Eligibility for Special Education Services](#)



https://ocali.org/ohio_parent_guide_to_ASD