Interdisciplinary Assessment of Young Children With Autism Spectrum Disorder

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Increasing numbers of young children are suspected of or have been identified with autism spectrum disorder (ASD; Filipek et al., 2000; National Research Council, 2001). Considering the core deficit areas associated with the disorder and its pervasive nature, an interdisciplinary assessment of a child’s strengths and challenges in communication, social interaction, and behavior is critical (Beatson & Prelock, 2002). As members of interdisciplinary teams, speech-language pathologists have an important role in the assessment process designed for children and families affected by autism. The purpose of this article is to describe a model for the assessment of children with ASD that includes families and leads to intervention planning. The assessment model is grounded in three key theoretical frameworks: family-centered care, cultural competence, and a strengths perspective.

Although initially developed and implemented as part of a federally funded training program, the Vermont Rural Autism Project (VT-RAP), this model has been used to increase the knowledge and skills of community-based practitioners in the assessment of children with ASD. Preliminary research examining the effectiveness of the assessment model reveals the positive impact of service provision that is family centered, culturally competent, and strengths based (Beatson & Prelock, 2002). From reading this article, it is hoped that speech-language pathologists will adopt a theoretical framework that meets the needs of children with ASD and their families and increases the role of families in the assessment process.
FAMILY-CENTERED CARE

In 1997, the Institute for Family-Centered Care (IFCC) articulated a contextual vision of children as existing within families existing within communities. This was a shift away from child-centered care to providing care that incorporated the wishes and goals of the family and extending that to create links among resources within the communities. Four core principles guided the IFCC in the newly articulated vision. First, people are to be treated with respect and dignity. Second, health care providers are to communicate and share information with families in ways that are both useful and affirming. Third, children and families are to be viewed as having strengths. Last, individuals, families, and providers are to collaborate in policy and program development, professional education, and service delivery.

Shelton and Stepanek (1994) also described key elements of successful family-centered care. These include the following:

- Recognize the family as a constant in the child’s life.
- Establish family–professional collaborations.
- Exchange complete and unbiased information.
- Honor cultural diversity.
- Recognize that families have different coping mechanisms.
- Facilitate family-to-family networking.
- Ensure that the systems are flexible and responsive.
- View children and families as having inherent strengths that serve as a foundation for growth and development.

Additionally, in order for helping practices to be truly effective, providers need to have technical competence, be trustworthy and caring, and involve families in their children’s care and future planning in a way that is meaningful (Dunst & Trivette, 1996; Mount & Zwernik, 1988). These elements of family-centered care are emphasized throughout the VT-RAP assessment model by including families as active participants and collaborators in the planning and implementation of the assessment of their children who have been suspected of or diagnosed with ASD.

CULTURAL COMPETENCE

In order to involve families in a meaningful way, their cultural world view needs to be understood and respected. Culture can be defined as the “shared implicit and explicit rules and traditions that express the beliefs, values and goals of a group of people” (Kalyanpur & Harry, 1999, p. 3). Cultural groups can be families, providers, systems, and in effect any self-identified group (Fadiman, 1997). When a provider comes together with a family, it is the meeting of several cultures—the provider’s personal background, his or her discipline and organizational culture, and the family’s culture. Sorting out cultural differences and finding common ground is the journey of cultural competence.

This journey toward cultural competence for providers can be seen as a continuum (Maternal & Child Health Bureau, 1997). At the bottom of the continuum is cultural destructiveness, where providers view cultural differences as a “pathology” and block access to appropriate services. Moving up the continuum, providers exhibit cultural incapacity, demonstrating low expectations for minority clients and displaying few cross-cultural skills. At the next level is cultural blindness, in which providers do not think about cultural differences or they see differences stereotypically. Providers then move to a level of pre-competence, where they display an initial understanding of the importance of differences, seek training, and begin to recognize their own cultural beliefs and biases. The next step on the continuum is cultural competence. This is attained when providers can see and accept differences, reflect on their understanding of differences, and integrate their cross-cultural expertise into clinical practice. Beyond cultural competence is cultural proficiency. At this stage, providers serve as teachers and mentors, collaborating in their cultural efforts and contributing to the field through writing and publishing. Throughout the VT-RAP assessment, team members are engaged in training to increase their recognition of their own cultural beliefs and biases. They are also encouraged to reflect on their understanding of differences and to integrate this understanding into the assessment process.

STRENGTHS PERSPECTIVE

Inherent in family-centered practice and cultural competence is the knowledge that all people have strengths. An individual’s or family’s potential, hopes, and dreams are actively elicited when a provider is working within the strengths perspective framework (Kisthardt, 1997; Saleebey, 1996, 1997). Their pain and challenges are acknowledged, and it is believed that their strengths will provide the bridge to solutions and healing. The strengths perspective stresses the development of a trusting relationship where helping is family directed. As much as possible, helping occurs in the natural environment with natural supports. A context of empowerment is created where all types of knowledge are valued, including family stories. When working within the strengths perspective, everyone belongs and no one is marginalized. The VT-RAP assessment process requires providers to see the strengths in children and families and to build on these strengths for intervention planning.

VT-RAP ASSESSMENT MODEL

The VT-RAP assessment model has been a highly effective approach to assessing the needs and planning programming for children with ASD and their families (Beaton & Prelock, 2002). Because each child with ASD
is unique and presents with differing strengths and challenges, a dynamic, multifaceted assessment process is critical. There are limitations to the use of measures that examine a single developmental area (e.g., language) and do so in only a standardized format. For example, many standardized tests are designed to recognize what a child cannot perform; therefore, they do not identify patterns of strengths and weaknesses across domains of communicative, socioemotional, language, cognitive, and physical development. In addition, there is discrepancy and uncertainty among professionals and families regarding the etiology of autism and the effectiveness of the various interventions. As a result, families are presented with a plethora of assessment and intervention options. They often require support and guidance throughout the early stages of assessment and diagnosis, as well as planning for intervention. Koegel, Koegel, Harrower, and Carter (1999) emphasized the need for teamwork, suggesting that responsibilities for implementing interventions for children with ASD should be distributed across agencies with no one individual being solely responsible. The VT-RAP assessment model is a program tailored to work effectively with individual families and children affected by ASD through its interdisciplinary teamwork and shared responsibilities in the identification of needs and implementation of resources.

Table 1 lists the steps of the VT-RAP interdisciplinary, community-based assessment model. In each step, the role of the family, collaboration with team members, and interdisciplinary input are emphasized.

Assignment of an Assessment Coordinator

The assessment coordinator is responsible for facilitating several elements of the assessment process: family support, intake, preparation for the preplanning assessment meeting, coordination of the actual assessment day, preparation for the postassessment planning meeting, and follow-up on recommendations made. A single team member is assigned as assessment coordinator to provide consistent support to the family. The assessment coordinator listens to the family’s story, introduces the family to the assessment process, and maintains weekly contact with the family. The assessment coordinator serves as a liaison to the community team; facilitates collaboration between the community and the VT-RAP team; prepares the interdisciplinary team for the actual assessment; and facilitates the discussion of objectives for the assessment, as well as for the development of recommendations. The assessment coordinator also integrates the documentation provided by team members into a written report and develops resource notebooks for the family and community team members. Finally, the assessment coordinator ensures action planning and follow-up for all recommendations made.

Intake

The assessment begins with a face-to-face intake with the family in its home or other location of the family’s choice and two members of the interdisciplinary team—the assessment coordinator and a family support person. During intake, background information on the child and family is gathered to guide the assessment. The family completes an information form focused on relevant family history, communication skills, health, and behavior, as well as a caregiver questionnaire (Wetherby & Prizant, 1993), which focuses on behavior regulation, social interaction, and play. The family also provides three key questions they would like the VT-RAP team to address during the assessment (e.g., How can we help our child play with his/her friends? Is our child on the autism spectrum? What are our child’s communication needs?). Possible questions that the intake team may pose to the family during the initial visit to the home include the following:

- What about your child brings you joy?
- What are your child’s strengths?
- What are you most worried about?
- What have you been told about your child?
- How does that fit with what you know?
- How would others describe your child’s strengths and challenges?
- What is your expectation for this assessment?

Table 1. Steps in the interdisciplinary assessment process for children with autism spectrum disorder.

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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<tbody>
<tr>
<td>1. Assignment of an assessment coordinator</td>
<td>Ensures that one individual has been identified as responsible for facilitating the elements of the assessment process.</td>
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<tr>
<td>2. Intake</td>
<td>Face-to-face meeting with the family in the home or a location of the family’s choice to gather background information on the child and family that will be used to guide the assessment.</td>
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<tr>
<td>3. Preassessment planning meeting</td>
<td>Meeting held with the interdisciplinary team, the family, and community team members to collaborate on the preparation of the assessment plan.</td>
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<tr>
<td>4. Assessment</td>
<td>Visit by the interdisciplinary team members to the child’s community (e.g., home, school, child care) to observe and interact with the child, interview family and community providers, and review records, following the assessment plan developed at the preassessment planning meeting.</td>
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<tr>
<td>5. Postassessment planning meeting</td>
<td>Meeting held with the interdisciplinary team, the family, and community providers to review the assessment findings and brainstorm key recommendations to address the priority needs of the child and family.</td>
</tr>
<tr>
<td>6. Report writing</td>
<td>Development of a working draft based on the input of the interdisciplinary team that is reviewed with the family and community providers for accuracy and assurance that questions raised have been answered.</td>
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<tr>
<td>7. Community follow-up meeting</td>
<td>Meeting held in the community to review the final report and create action plans for implementing the recommendations.</td>
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<tr>
<td>8. Resource notebook development</td>
<td>Binder of selected resource materials prepared for the family and community providers to increase their knowledge base around the diagnosis of autism spectrum disorder, intervention strategies with and without a research basis, and available community contacts.</td>
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The assessment coordinator develops a tentative plan with the family for visiting at home, school, and elsewhere in the community (e.g., childcare).

The child’s primary health care provider and educational case manager are also interviewed as part of the intake process. Each of these individuals formulates three key questions based on his or her knowledge and experience with the child being assessed.

Upon completion of an extensive intake process, the VT-RAP team is more able to identify the family’s support network. The team uses the information gathered to understand the family’s value and belief system better and to collaborate with the family to determine its priorities.

Preassessment Planning Meeting

In preparation for the actual assessment day, a meeting is held with the VT-RAP interdisciplinary team, the family, and community team members. Twelve disciplines (i.e., speech-language pathology, audiology, social work, developmental pediatrics, nursing, psychology, family support, nutrition, public administration, occupational therapy, physical therapy, and education) are present at this preassessment meeting for the assessment of a child diagnosed with or suspected of ASD.

The assessment coordinator uses two specific tools (i.e., genogram and ecomap) to represent the child and family to the entire VT-RAP team and community members at this preassessment planning meeting.

- A **genogram** is a tangible, graphic representation of the family structure (Goldrick & Gerson, 1985; Hartman & Laird, 1983). Its value lies in the ability to assess and visually display relevant information about family history quickly (e.g., constellation of the family living in the home, number of siblings, family members with specific illnesses or disabilities, first- and second-generation relatives who are living and deceased; Smith & Prelock, 2002).

- An **ecomap** is a picture of the family in its environment and situations within that environment (Compton & Galaway, 1984; Goodluck, 1990; Hartman, 1979; Hartman & Laird, 1983). It displays available resources (e.g., respite, funding, educational programs, community centers), portrays the energy flow of these resources (i.e., from family to resource and vice versa), and highlights the level of stress for other events occurring in the environment (e.g., work, child care, health care; Smith & Prelock, 2002).

The assessment coordinator, in collaboration with the family, presents the family’s story, highlighting the questions that were raised during the intake process. To ensure that meetings are collaborative and efficient, the team works to establish mutual goals, share responsibility, and establish parity among all participants (Friend & Cook, 2000). More specifically, norms, agendas, and roles are introduced and modeled in this preassessment planning meeting.

**Norms** are the ground rules that guide meeting behaviors. The interdisciplinary assessment team establishes these norms to prevent potential difficulties when interacting and communicating in large interdisciplinary meetings. Examples of team meeting norms might include the following:

- **Meetings start on time.**
- **All ideas are listened to and respected.**
- **Diverse perspectives are valued.**
- **If families are not present, an empty chair is used to represent their presence symbolically.**
- **Person-first language is used (i.e., child with autism versus autistic child).**

**Agendas** are set and reviewed at the beginning of each meeting. They are used to list the schedule of events, to focus participants, and to help the facilitator maintain control of the meeting (Rainforth & York-Barr, 1997). Agendas usually include the topic(s) of discussion, persons responsible for leading the discussion, and the amount of time allotted for each topic. To ensure that all participants are heard, agendas are built as a team at the beginning of each meeting. Therefore, everyone present has the opportunity to add to the agenda.

To encourage full participation by those attending the meeting, roles are assigned. Team members volunteer to take on specific roles that are rotated at future meetings. Roles used include the following:

- **Facilitator:** Manages the discussion and ensures that the agenda is followed.
- **Recorder:** Takes meeting minutes (capturing main discussion areas and decisions made) and distributes these to all team members.
- **Timekeeper:** Ensures that time limits are set for agenda items, keeps track of time on each item, and helps the team renegotiate times when necessary.
- **Jargon buster:** Listens for jargon or unfamiliar terminology and asks for clarification for the group.
- **Proc**essor:** Evaluates the process of the meeting, including identifying whether or not the agenda was met and how respectful team members were, noting discussions that went well and those that were challenging, and describing what should stay the same or what should be done differently at subsequent meetings.
- **Wellness provider:** Provides a reading, story, or reflection that ends the meeting on a high note.
- **Equalizer:** Ensures equal “air time” for all team members so that no one person monopolizes the conversation or inhibits other team members’ expression of ideas.
- **Keeper of the rudder:** Reminds the group to get back “on topic” in instances when all or some team members have conversations that are not relevant to the agenda.

In keeping with a family-centered philosophy, families help define those aspects of their child’s development and characteristics of the environment that should be evaluated. Joint attention, sensory sensitivity, fine and gross motor responses, peer interactions, play skills, verbal and nonverbal
aspects of communication, receptive language, attention, temperament, hearing, nutrition and feeding skills, toileting, and sleep are examples of the different areas that are often the focus of assessment for children with ASD. In addition, the interdisciplinary team is asked to assess the environmental arrangement and accommodations at home, school, and elsewhere in relevant community settings. In defining the areas for assessment, the families also suggest those disciplines and family supports in which they would like to be involved during the assessment. Decisions are made about the environments that are to be examined and the individuals to be interviewed. Some families ask to have their children observed in childcare settings, at a friend’s home or a local recreation facility, within specific school activities (e.g., opening group, independent tasks, snack), and on the playground. Members of the immediate and extended family, teachers, individual aides, speech-language pathologists, occupational therapists, physical therapists, siblings, and primary health care providers might be some of the individuals interviewed. The relevant medical and educational records are also listed for review, with guidelines for obtaining specific information that will help to address the questions being asked.

The outcome of the preassessment planning meeting is the development of an action plan for the community-based assessment. This planning meeting engages families and community providers in sufficient discussion about the action plan so that they share a common understanding of the goals of the assessment and the related activities. Within these meetings, “probing” questions such as “Will this suggestion give us the information we need to answer the questions asked?” are used to confirm mutual understanding (Filer & Mahoney, 1996).

Assessment

During the actual community-based assessment, families play a crucial role. Typically, they are involved in components such as home observation and videotaping of the parent/sibling/child interaction. Some parents participate in the assessment by observing their child alongside service providers or interacting with their child as service providers gather data. This side-by-side participation helps to ensure that families and providers share a common experience for describing the assessment and its outcomes (Filer & Mahoney, 1996). Parents also participate in the completion of checklists and observational assessment tools.

Interdisciplinary team members pair up to make their observations and to interview providers or family members who were defined in the action plan from the preassessment planning meeting. This interdisciplinary partnership during observation and interviewing is done to obtain more than one discipline’s perspective on what is seen and heard. Observations and interviews often focus on assessing unconventional verbal behavior (e.g., echolalia, excessive questions, perseverative speech; Prizant & Rydell, 1993; Prizant, Wetherby, & Rydell, 2000), pivotal observation behaviors (e.g., motivation, self-initiation, self-regulation, empathy, social interaction; Koegel, Koegel, & Carter, 1998; Koegel et al., 1999), friendship behaviors (e.g., sharing, suggesting play ideas, affection, assisting, lengthy encounters, and reciprocity; Strain, Kohler, & Goldstein, 1996), and/or play (e.g., solitary, parallel, associative, cooperative, constructive, functional, symbolic; Linder, 1993; Westby, 1980, 1988; Wolfberg, 1995, 1999).

In addition to participating in observations and interviews, team members may decide that it is necessary to administer formalized tools, particularly if there is a question of diagnosis. Screening (e.g., Autism Behavior Checklist [ABC], Krug, Arick, & Almond, 1993; Checklist for Autism in Toddlers [CHAT], Baron-Cohen, Allen, & Gillberg, 1992; Australian Scale for Asperger’s Syndrome, Garnett & Attwood, 1998; the Modified Checklist for Autism in Toddlers [M-CHAT], Robins, Fein, Barton, & Green, 2001) and diagnostic (e.g., Asperger Syndrome Diagnostic Scale [ASDS], Myles, Bock, & Simpson, 2001; Autism Diagnostic Observation Schedule–Generic [ADOS–G], Lord, Rutter, DiLavore, & Risi, 1999; Childhood Autism Rating Scale [CARS], Schopler, Reichler, & Ruchen-Renner, 1988; Gilliam Asperger’s Disorder Scale [GADS], Gilliam, 2001; Gilliam Autism Rating Scale [GARS], 1995) tools currently exist to assess children suspected of ASD. These assessment tools examine challenges in communication, social interaction, play, and behavior that are commonly described for children with ASD. Completion of these tools may involve interviews with the family or require team members to observe and/or interact with the child. The use of more formal diagnostic instruments helps the VT-RAP team to differentiate the severity of presentation for children being newly diagnosed with ASD and to assess any change in presentation of symptoms for those children who were previously diagnosed with ASD. If the results of the screening or diagnostic tools indicate autism, the VT-RAP team reviews the diagnostic criteria for pervasive developmental disorders/autism (American Psychiatric Association, 2000). This is often done with the family and community team on the day of assessment or at a time scheduled soon after the assessment day. The team offers impressions and provides examples of behavior that would be indicative or not indicative of the specific criteria and asks family and community team members to do the same.

Other areas of assessment carried out during the assessment day may include sensory-motor skills (Sensory Profile Caregiver Questionnaire; Dunn, 1999), toileting, sleeping, and/or nutritional habits. Again, assessment areas are determined by the entire team during the preassessment planning session and are driven by the family’s primary questions. If possible, all targeted observations and assessment tools are completed on the day of the VT-RAP assessment. Interviews and records reviews also occur at this time, but may spill over into another day if some individuals are unavailable to meet for their interviews or if records are missing.

Following the assessment, team members, including the families, review the assessment data. Family participation in the assessment and review ensure that the information collected is representative of what families perceive as their child’s skills and behaviors. Community providers are also asked to determine how representative the assessment data
gathered are in comparison to the typical skills and behaviors exhibited by the child suspected of or identified with ASD in their setting.

**Postassessment Planning Meeting**

Once the assessment is completed, another planning meeting is scheduled. The format of this meeting, in terms of roles, agenda setting, and meeting norms, is similar to the preassessment planning meeting described earlier. At this meeting, questions identified at intake are reviewed and those who participated in the assessment offer responses to these questions. Once all team members provide input, they brainstorm possible recommendations and consensus is built around three to five key recommendations identified as meeting the needs of the family and child and as addressing the key questions asked by the family, community team, and primary health care providers.

Open discussion of possible recommendations provides a common framework from which expectations for service delivery are drawn. In addition, this meeting allows for family and community provider participation in a collaborative, interdisciplinary discussion of the variety of services that could be accessed to address the family’s priorities.

**Report Writing**

The next step in the assessment process is completion of the interdisciplinary report. The report is written to answer the family’s questions and provide recommendations based on information obtained through the assessment process and postassessment planning meeting. A working draft of the report is generated and given to the family to review. The family has an opportunity to review the report with the assessment coordinator. This enables the family to make modifications with the assessment coordinator collaboratively in order to ensure that the report satisfactorily answers the family’s questions and addresses the needs of all family members.

Once the family completes its review of the report, community members are asked to review the working draft for accuracy. Community members are also given an opportunity to make modifications in collaboration with the assessment coordinator.

**Community Follow-up Meeting**

As the assessment process nears an end, a community follow-up meeting is held. At this meeting, all service providers are brought together with the family to discuss outcomes of the assessment, provide recent updates since the assessment was completed, and review the recommendations provided in the written report. For each of the key recommendations agreed on by the family, community providers and interdisciplinary assessment team action plans are developed. In addition, a time line for implementation and those responsible for following up on the action plans are determined. This ensures that community providers and the family share a common understanding of those recommendations that will be implemented as part of the service delivery and programming provided for the child.

**Resource Notebook Development**

To exchange information relevant to the findings in the assessment and to provide literature-based support for recommendations made, a resource notebook is developed for the family and agencies/community professionals involved in providing services. The resource notebook is a three-ring binder that includes relevant research and practice articles regarding the child’s particular diagnosis or challenges, handouts on intervention strategies, community contacts for health care and respite, assistance for funding augmentative and alternative communication devices, and suggestions (e.g., sensory, acoustic) for improving the child’s environment. The knowledge base and skills of the families and community providers involved help determine the selection of materials included in the resource notebook.

**VALUED OUTCOMES OF FAMILY-CENTERED INTERDISCIPLINARY PRACTICE**

It is important to evaluate the effectiveness of a model of service delivery such as the VT-RAP interdisciplinary assessment process to determine if, in fact, the process addressed the priority needs that families identified for their children with ASD. A qualitative study conducted with five families of children with ASD who participated in the VT-RAP interdisciplinary assessment process revealed the outcomes families valued most (Beatson & Prelock, 2002). Families described that when the interdisciplinary team saw their children in their homes, a context of empowerment was created. Families also reported that the technical competence in service provision that was modeled by the VT-RAP interdisciplinary team helped their struggling school teams to shift their attitudes regarding the role of families and the strengths of children with ASD to be considered in service provision. The family-centered, culturally competent, and strengths-based framework that guided the VT-RAP interdisciplinary assessment process created a powerful change for families, their children, and their school teams. One parent described it this way:

> It is a whole attitude shift and once you make that, things fall into place. I think that’s what RAP does. It pushes that button that gives people an attitude shift, I know it did for the school team…it made us feel like someone was coming to our rescue. We dialed 911. (Beatson & Prelock, 2002, p. 51)

Instead of being marginalized, parents became dynamic team members whose knowledge was sought and valued.

**IMPLEMENTING THE ASSESSMENT MODEL**

Although not all schools will have access to an interdisciplinary assessment team as has been described here, suggestions are offered that professionals working in
schools or providing consultation to schools can use to improve outcomes for children with ASD and their families. First, in many ways, schools are small interdisciplinary communities, with a diverse collection of professionals working together, including speech-language pathologists, general and special educators, psychologists, health care professionals, and occupational and physical therapists. When assessment of a child diagnosed with or suspected of having a diagnosis of ASD is undertaken, school teams should make every effort to involve professionals from multiple disciplines in all aspects of the assessment process so a variety of perspectives are represented and diverse recommendations are considered. Individuals from varying disciplines should be encouraged to partner and collaborate in multiple aspects of the assessment process from interviewing and observation to brainstorming in the formulation of recommendations.

When an outside consultant is conducting an assessment, teams should establish a primary contact person during the assessment process. This person should be responsible for scheduling observations and meetings, providing access to needed records and background information, responding to questions, or identifying those individuals who are able to provide the needed information. The idea of a contact person is similar to the concept of the assessment coordinator role that was used in VT-RAP (described earlier) and was essential in streamlining the process.

Eliciting three key questions from family members to be addressed during the assessment process is a central step to the VT-RAP process. School teams working with families and children affected by ASD would also benefit from this approach. It ensures that the assessment process remains family centered and focuses on the families’ priorities for their children.

Similarly, encouraging teams or consultants to form three to five key recommendations for each content area of an assessment is equally useful in focusing and prioritizing the feedback provided to teams and family members. This also ensures that the important outcomes and action plans that result from the assessment process can be addressed as opposed to being lost among a series of recommendations that have not been prioritized and often hinder teams acting on any recommendation.

The concept of a resource notebook is one that can be useful to teams supporting children with ASD in multiple ways across settings. Perhaps most importantly, with assessment or consultation, often the professionals who make recommendations differ from those who will be responsible for supporting and implementing those recommendations. Given the realities of professional workloads and time demands, this often slows the process of moving implementation of program recommendations forward. One way that teams can address that challenge is to provide resources to facilitate the delivery of information, training, and capacity building related to their specific recommendations. In VT-RAP, the compilation of a resource notebook was an effective tool for sharing specific information about recommendations with teams. An added value of this format is that the notebook can “travel” with the child’s records and be shared with new team members who may join the team after the assessment and implementation of recommendations was completed.

Finally, many of the teaming structures and concepts (meeting norms and roles, agenda) used in the VT-RAP assessment process are applicable and valuable in a variety of agency and school settings, regardless of the location, topic, or participants in any given meeting. These meeting elements are central to helping teams to remain family centered, value diverse perspectives, use time efficiently and productively, and remain focused on goals and outcomes of the assessment process.

**SUMMARY AND CONCLUSIONS**

School-based speech-language pathologists can draw several lessons from the experiences of the VT-RAP interdisciplinary team in its service provision to children with ASD and their families. First, speech-language pathologists must commit to a journey of family-centered and culturally competent practice. They should recognize the inherent strengths within families and understand that families are the constant in the lives of their children. Families have expert knowledge about their children that is essential for the team to know and understand. Practitioners should solicit family stories and honor what families have to say. Families and children should be visited in their homes. Practitioners might offer having team meetings in the homes of families, giving them the opportunity to determine the most comfortable environment in which to talk about the needs of their children. It is also critical that practitioners share what they know in a manner that is without bias and is easily understood.

Second, speech-language pathologists should be able to articulate their own cultural background and that of their profession and the organization within which they work. In addition, they must be able to explain their cultural view to others and solicit that of the families and other professionals with whom they interact. By doing this, team members, including families, discover ways in which they differ and some common ground on which they can build relationships.

When these skills in family-centered care and cultural competence are practiced, attitudes shift. Only then can providers begin to understand the families’ journey and collaborate with families in developing and implementing programs for their children with ASD. This shift in attitude enables children, families, and providers to move forward in a manner where everyone grows in their efforts to address the complexities of ASD that lead to valued life outcomes.

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