

Foundations of Autism Spectrum Disorders: An Online Course

Session 4 Guiding Principles

National Professional Development Center on Autism Spectrum Disorders (2008). Session 4: *Guiding Principles*. In *Foundations of autism spectrum disorders: An online course*. Chapel Hill: FPG Child Development Institute, The University of North Carolina.

Introduction

Session 4 content covers nine important principles for working with learners with autism spectrum disorders (ASD) and their families. Even though the guiding principles presented in this session may not meet the same rigorous scientific criteria that our project has adopted for focused intervention practices, they provide a sound foundation for high quality programs, services, and interventions contained in the literature for learners with ASD and their families.

Session 4 Guiding Principles

Upon completion of this section, learners will:

1. describe the importance of understanding ASD when planning, implementing, and continuously monitoring intervention and education for learners with ASD.
2. discuss the importance of family-centered practices and honoring diversity in the provision of effective intervention and education.
3. describe three benefits of using a collaborative interdisciplinary approach.
4. discuss the definition of evidence-based practices used by the National Professional Development Center on ASD.
5. describe the importance of providing interventions within naturalistic and least restrictive environments.
6. identify two components of the Individualized Family Service Plan (IFSP) or Individual Education Plan (IEP) that assure access to optimum learning environments.
7. identify and describe three core implementation components required to successfully adopt an innovation such as evidence-based practices.

In addition to selecting practices that are evidence based; supports, intervention, and education for individuals with ASD and their families should be provided within a framework of common values and recommended practices. These common values and recommended practices can be referred to as guiding principles and are discussed in the following section. These nine guiding principles include:

- understanding autism spectrum disorders,
- providing family-centered practices that honor diversity,

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- collaborating as an interdisciplinary team,
- using evidence-based practices,
- using data collection to guide intervention,
- providing services in natural and least restrictive environments,
- providing access to optimum learning environments and to the community,
- planning for transitions, and
- embracing a systems approach.

Understanding Autism Spectrum Disorders

A thorough understanding of the characteristics associated with ASD provides a solid foundation for the provision of effective intervention and education for learners with ASD. This understanding of the core characteristics of ASD and the heterogeneity of individuals with ASD helps early interventionists, teachers, and other professionals (referred to as team members throughout this online course) to consider the comprehension, learning, and behavioral difficulties that individuals with ASD are likely to have as they identify evidence-based practices that can best meet the learners individualized needs. As described earlier, all individuals with ASD have challenges – sometimes subtle, sometimes very obvious – in social understanding and social skills. Almost all have difficulties with some aspects of communication, and often with processing spoken language. On the other hand, visual processing can be a relative strength. Sensory processing problems are common. Inflexible and sometimes concrete thinking, as well as challenges in planning and organization, can cause difficulties in everyday life. Extracting the most important information in a situation or task can be difficult for individuals with ASD, and they often have strong interests that can cause difficulties but that can also be employed constructively. A thorough understanding of these and other characteristics of ASD and how the characteristics manifest in specific individuals should provide the foundation for individualized family service and education plans and for interventions for challenging behaviors. Areas of particular importance for learners with ASD include individualizing intervention/instruction, promoting generalization of skills across settings and time, and promoting independence and functional skill acquisition. For young learners with ASD, an emphasis on providing opportunities for imitation (Ingersoll, 2010) and developing joint attention skills (Kasari, Paparella, Freeman, Jahromi, 2008) would be developmentally appropriate.

Individualization

As noted earlier, some learners with ASD function intellectually in the average to above average range, while others may have severe to mild intellectual impairments. Some may be nonverbal, while others have relatively intact communication and language skills. Although all learners with ASD will have challenges with social relationships, these challenges may be mild to severe. Similarly, behavioral needs can vary significantly from individual to individual. Finally, because families play such an important role in their children's outcomes, team members must consider family priorities and honor diversity within families. For these reasons, no intervention or

curriculum should be uniformly applied to everyone with ASD. Goals, specific interventions, and strategies for implementing interventions must be individually determined, based on ongoing assessment, and should clearly reflect an understanding of learning style, strengths and weaknesses, and developmental skill levels. Individuals with ASD often have strong interests that can be used as incentives to motivate them to engage in social interactions; play, learning, and work activities; and to communicate with others. Goals and strategies also should be guided by family priorities, functional considerations, and the individual's age and developmental levels (National Research Council, 2001).

Promoting Generalization of Skills Across Settings and Time

As noted earlier, learners with ASD can become reliant on cues from others and often have difficulty generalizing skills from one context to another. To enhance generalization, learners with ASD should be provided with information about the meaning (rationale for) and relevance of the skills they are learning, often by applying them to "real life" situations and activities across multiple contexts. Concurrently, it is important to maximize independence in using these skills (National Research Council, 2001).

Promoting Independence and Functional Skill Acquisition

Helping individuals with ASD become independent and socially responsible is an important life-long goal. At all ages, it is important to teach skills that will facilitate self-care, domestic and vocational functioning, leisure and recreational activities, and community living, as well as social, communication, and academic abilities (National Research Council, 2001).

Providing Family-centered Support and Honoring Diversity

Family-centered Support.

Family-centered support and practices have been a cornerstone of recommended practices for early intervention and preschool education for the past 30 years and have more recently been accepted as a standard of care for individuals with special health care needs of all ages (Maternal and Child Health Bureau, 2005; Sandall, Hemmeter, Smith, & McLean, 2005). Family-centered support involves a collaborative partnership between families and professionals to promote optimal child development and learning. This partnership is characterized by:

- respectful and trusting relationships,
- open communication,
- emphasis on family strengths and success,
- recognition that families are the constant in their children's lives,
- promotion of family choice,
- promotion of family-to-family support,
- promotion of practices and systems that are family friendly,

- viewing families holistically, and
- honoring diversity and family values (Hatton, McWilliam, & Winton, 2003; Maternal and Child Health Bureau, 2005).

The pervasiveness of symptoms associated with ASD result in significant challenges for families, teachers, other practitioners, and caregivers. The unpredictability of the behavior of learners diagnosed with autism and the social-interpersonal ramifications experienced by families may accentuate the stress these families experience beyond that experienced by families of learners diagnosed with other disabilities (Bristol, 1984; Schopler & Mesibov, 1984). Additional family and community resources may be required to address the needs of individuals with ASD and their families (Rounds, Weil, & Bishop, 1994). Mary (1990) suggested that the family as a whole be regarded as the unit of intervention given the complexity of ASD, a recommendation that is consistent with family-centered support.

In addition to completing early research that demonstrated that discrete trial training, a specific type of applied behavior analysis, could be used to teach skills to individuals with autism, Lovaas and colleagues (1973) demonstrated the beneficial impact of including the family as part of the treatment team. Specifically, these researchers found that learners who returned to families prepared to support their development and learning maintained their treatment gains better than learners who went to institutional settings. Others also have recognized the importance of families as playing a key role in the effective treatment of their children with ASD (Harris, 1994; Howlin, 1989; Kozloff, 1984; Lovaas, 1987; Marcus & Schopler, 1989; Schopler, Mesibov, Shigley & Bashford, 1984; Schopler & Reichler, 1971; Schreibman, Koegel, Mills, & Burke, 1984; Volkmar, Cook, & Pomeroy, 1999). Proponents of ABA typically emphasize the role of parents in treating children, and, in some cases providing oversight and management of home-based ABA programs. Other programs, such as the Developmental Intervention Model (Greenspan & Weider, 1999), the TEACCH Model (Schopler, Mesibov, & Baker, 1982), and the Denver Model (Rogers, Osaki, Reaven, & Herbison, 2000), also have obtained positive results by involving parents as active participants in children's treatment programs.

Consistent with the adoption of family-centered support and services in the broader community of special education and medical care for learners with special health care needs, the field of autism now readily accepts the importance of family-professional collaboration in the design and implementation of intervention services and education for learners with autism (Schopler & Mesibov, 2000). The National Research Council (2001) recognized that benefits associated with family involvement in children's treatment extend beyond the teaching of adaptive skills and managing the behavior. Such intervention maximizes children's learning, improves the quality of family life, and may enable families to sustain their efforts with their children over time. To achieve

these results, though, families may need both initial training and ongoing support that is collaborative and family-centered.

Read

Please read this downloadable document on Family-Centered Care by clicking on the link below.

<http://www.medicalhomeinfo.org/downloads/pdfs/JointStatement.pdf>

Honoring Diversity.

Although Kanner (1943) initially proposed that autism might be more prevalent in families with higher levels of education, autism appears to occur at equal rates in families of all ethnic and cultural backgrounds (USDHHS, 2002; Wing, 1993). Therefore, those involved in the diagnosis and treatment of ASD should expect to interact with families with a wide range of social and cultural characteristics.

Culture can be defined as a learned system of meaning and behaviors passed from generation to generation (Carter & Qureski, 1995; Fairchild, 1970; Triandis, 1972). It includes behaviors, beliefs, attitudes, and values shared by a group that are learned, not inherited, and that are acquired through socialization rather than through direct teaching (Bryan, 1999). It is important to be aware of differences in cultures and to be sensitive to the challenges these differences may present. In addition to cultural diversity, families are also diverse in family structure, living conditions, religious beliefs and practices, and values. Aspects of family diversity include: single- versus two-parent families, parents of same or different genders, differences in socioeconomic status, differences in values, and differences in religion and/or spirituality.

Socioeconomic status, educational levels, family values, and many other factors transact to affect how families respond to having a child who has ASD. Additionally and as importantly, members of different cultures, religions, and nationalities may interpret and respond to disabilities differently. Team members should be sensitive to family backgrounds, preferences, and comfort levels when interacting and collaborating with all families, including families whose cultural and ethnic backgrounds differ from their own.

When the primary language of families and program staff is different, communication is likely to be severely compromised. The ability to speak English does not guarantee that a family will understand programmatic information presented in English (Bailey et al., 1999). Effective communication can be enhanced through the awareness and understanding of the role that non-verbal communication plays. For example,

information may be transmitted through the context of the situation, the relationship between the parties, and physical cues (Hall, 1976; 1984). Therefore, printed information about programs and services should be available in the primary languages spoken by families. Interpreters and translators can be used to assure that information and resources are accessible to families for whom English is a second language; however, care must be taken in maintaining confidentiality and in training interpreters and translators so that they have a clear understanding of their roles and the services that they are describing (Cho, Singer, & Brenner, 2000; Lynch & Hanson, 1992; Park & Turnbull, 2001).

The Surgeon General's Report, "Mental Health: Culture, Race and Ethnicity" (USDHHS, 2001), identifies barriers that may influence the extent to which families from non-dominant cultures access and participate in treatment programs. Families may think that programs and services are not relevant due to their values. When families value group behavior rather than individuality, harmony with the environment rather than control over it, and the past or present rather than the future, they may experience challenges in securing services from the dominant culture of the United States that values individuality. Without an awareness of beliefs that underlie professional practice, professionals can de-legitimize the cultural authority of people from non-dominant cultural backgrounds (Harry & Kalyanpur, 1994).

Finally, practitioners must respect the level of involvement that families choose in supporting their children with ASD. Families should determine the extent to which they wish or are able to be involved in the service coordination or treatment process (Dunst, Trivette & Deal, 1988). Assuming an active role in service coordination and treatment may be threatening to some families (Chan, 1986). Practitioners must remember that "one size doesn't fit all," and the importance of being responsive to the diversity inherent in the individuals and families they serve. Awareness of customs, parenting styles, traditions, values, beliefs and attitudes about disabilities is essential for team members working with families and learners with ASD to be culturally competent (Lynch & Hanson, 1992; Sue & Sue, 1990). Although learning about others is an important step in developing cultural competency, it is also important for team members to constantly reflect upon their own values and beliefs and how they may affect interpersonal interactions with people who hold different values, beliefs, and traditions.

Read

Please view the article, "Working with Culturally and Linguistically Diverse Families" (Bruns & Corso, 2001) at the url listed below.

<http://www.ericdigests.org/2002-2/diverse.htm>

Collaborating as an Interdisciplinary Team

Autism is a complex disorder that impacts multiple areas of development, including communication, social interaction, and behavior. Many learners also have health issues such as allergies or seizure disorders. To provide the most effective assessment and intervention, a collaborative team approach is critical. While IDEA (1997, 2004) uses the term *multidisciplinary*, the intent is to ensure that more than one discipline is involved in assessment, planning, implementing, and monitoring of services (Hatton et al., 2003). *Multidisciplinary* teams are apt to treat each developmental domain as a separate entity, with little or no time spent together discussing the interrelatedness of assessment findings from each discipline. Lack of communication among members of multidisciplinary teams may lead to conflicting opinions and inconsistent recommendations that confuse and frustrate families.

An *interdisciplinary* approach encourages discussion among team members and provides a more holistic view of individuals with ASD. In addition, when findings from multiple disciplines are shared, team members can consider how findings from multiple disciplines (occupational therapy, behavior, communication/language) interact to influence outcomes (Klin, Saulnier, Tsatsanias, & Volkmar, 2005). Interdisciplinary teams are more likely to address not only the core symptoms of ASD, but also associated characteristics (e.g., sensory differences), and the impact these may have on learning and behavior. While each discipline has its own expertise, many skills may be taught incidentally to other members of the team across time, resulting in shared expertise. When team members have common goals, learners have more opportunities to learn and practice new skills. Ideally, as teams begin to purposefully teach skills across disciplines and engage in more systematic sharing of information and cross-disciplinary training, they may move toward a *transdisciplinary* team model (Hatton et al., 2003) in which one team member assumes the role of liaison to learners and families, with input and support from the other team members.

Given the complexity of assessing and providing services to individuals with autism, an interdisciplinary, rather than multidisciplinary, team model is recommended. The interdisciplinary team should meet regularly to discuss progress and to monitor and update intervention strategies as needed. Minimally, the intervention team should consist of special and regular education teachers, speech-language pathologist, occupational therapist, psychologist, the child's family, and perhaps a behavior specialist. Optimally, the child's family will play an integral role on the team, starting with their earliest concerns and priorities about development and learning to intervention planning, implementation, progress monitoring, and to transitioning across program levels and grades. Depending on learners' unique profiles of strengths and needs, the frequency and intensity of services from each discipline may vary. In addition, as children age, the composition of the team may change, with the family remaining the constant.

Using Evidence-based Practices

Evidence-based practices (EBP) are practices for which there is scientifically-based research that demonstrates efficacy for use with learners with ASD. This research involves the application of rigorous, systematic, and objective procedures to obtain reliable and valid knowledge for intervention and educational activities and programs. In other words, practices that are evidence-based have been shown to be effective.

The National Professional Development Center on ASD (NPDC-ASD) has adopted the following criteria for evaluating interventions and practices used with individuals with ASD. These criteria are being used to develop modules on EBP that practitioners can use to address the goals and objectives on the IFSPs and IEPs of learners with ASD. This online course provides information that will help practitioners develop a solid foundation on which to implement EBP. To be considered an evidence-based practice by the NPDC-ASD, a practice must meet one of the following criteria.

Type 1: Randomized or quasi-experimental design studies. For a practice to be considered evidence-based, two high quality experimental or quasi-experimental group design studies in peer-reviewed journals must have demonstrated efficacy for the practice. High quality studies are ones in which critical design flaws that create confounds to the studies do not exist, and design features allow readers/consumers to rule out competing hypotheses for study findings.

Type 2: Single-subject design studies. For a practice to be considered evidence-based, three different investigators or research groups must have conducted five high quality single subject design studies. High quality is reflected by (a) the absence of critical design flaws that create confounds and (b) the demonstration of experimental control at least three times in each study.

Type 3: Mixed methodologies. A focused intervention may also be considered evidence-based if efficacy is demonstrated by one high quality RCT or quasi-experimental group design study and three high quality single subject design studies conducted by at least three different investigators or research groups (across the group and single subject design studies).

Using Data to Guide Intervention

Assessment is the process of gathering information to make decisions (McLean, Bailey, & Wolery, 1996). For learners with ASD, assessment may be used to determine eligibility for services; to identify strengths and needs for IFSP and IEP planning, implementation, and monitoring; and to guide day to day implementation of EBP and strategies needed to address IFSP and IEP goals. In this section, assessment refers to

gathering information for intervention planning, implementation, and progress monitoring and involves the following steps:

1. gathering information about existing strengths and needs,
2. designing or selecting interventions and EBPs to maximize strengths and meet needs, and
3. consistently and continuously evaluating the intervention to determine whether and/or how it should be adapted.

Information should be gathered over multiple occasions or sessions, using multiple methods of assessment, such as direct observation and interviews with key team and family members. When gathering assessment information, consider the following points: (1) assessment information should be used to identify goals and objectives as well as to prioritize those goals and to monitor progress of goal attainment; (2) authentic and informal assessment methods should be used to supplement information gathered by formal assessment tools; (3) family members should be involved in the assessment (e.g., to help identify relevant goals and to learn more about how the child functions in home and community settings); and (4) assessment information should be gathered and shared by multiple team members to holistically describe the current level of functioning, and to identify and/or develop individualized interventions to best meet needs (McLean et al., 1996).

Assessment of Family Concerns and Priorities

If families are encouraged to actively participate in their children's program, a careful and thorough assessment of their concerns and priorities is essential. Part C of IDEA requires that infants and toddlers with disabilities and their families receive a "family-directed assessment of the resources, priorities, and concerns of the family and the identification of the supports and services necessary to enhance the family's capacity to meet the developmental needs of the infant or toddler" (IDEA 2004, Part C, Section 636, Individualized Family Service Plans, p. 105). While not required under Part B of IDEA, (for learners 3-21 years of age), information provided by parents is considered one of the assessment strategies that should be used to determine whether learners meet eligibility requirements for a disability and to identify the content of IFSPs and IEPs. Family-centered practices, such as an assessment of family concerns and priorities, are recommended across the life span. Because of the need to individualize intervention and education, to assure individualization of interventions and generalization of skills, and to promote communication and social interactions, practitioners who serve individuals with ASD of varying ages should informally assess family priorities and concerns to assure that families and practitioners implement interventions consistently across settings.

An assessment of family concerns and priorities should identify families' preferences for involvement and the desired level of involvement in implementing and monitoring interventions. While active family participation in intervention and education has been

positively correlated with child outcomes, it should not be pursued at the expense of family stability. Because family well being and stress are associated with access to care and the availability of formal and informal supports, team members should consider informal assessment of the supports and services that families access.

Providing Services in Natural (or Naturalistic) and Least Restrictive Environments

One of the foundational principles of IDEA, Part B (students with disabilities, ages 3 to 21 years) is the right of learners with disabilities to have a free and appropriate public education (FAPE) and an individualized education program, or IEP (IDEA, 2004). When determining placement, based on the IEP, states and IEP teams must ensure that “to the maximum extent appropriate,” learners with disabilities are educated with learners who are not disabled in the least restrictive environment (LRE). According to IDEA, 2004, learners should not be placed in special classes, separate schools, or removed from the regular educational environment in which they would receive services if they did not have disabilities unless the nature or severity of the disability makes it impossible to achieve satisfactory results with supplementary aids and services (Assistance to States for the Education of Children With Disabilities and Preschool Grants for Children With Disabilities; Final Rule, 34 C.F.R., 2006). Placement decisions should be determined on an annual basis, based on the IEP, and should be “as close as possible to home” for the child. In other words, learners with disabilities should be placed in the schools they would attend if non-disabled. When identifying the least restrictive environment, potential harmful effects and the quality of services should be considered. Learners should not be removed “from education in age-appropriate regular classrooms solely because of needed modifications in the general education curriculum” (Assistance to States for the Education of Children With Disabilities and Preschool Grants for Children With Disabilities; Final Rule, 34 C.F.R., 2006). Also, to the maximum extent appropriate for individual needs, learners with ASD should be able to participate in extracurricular services and activities (including meals, recess, art, music, physical education).

Infants and toddlers with disabilities under Part C of IDEA must receive early intervention services that meet their developmental needs, as determined by the individualized family service plan team and that “to the maximum extent appropriate, are provided in natural environments, including the home, and community settings in which learners without disabilities participate” (IDEA, Public Law 108-446, Section 635, 2004, p. 103). Providing early intervention services “in a setting other than a natural environment that is most appropriate, determined by the parent and the individualized family service plan team, occurs only when early intervention cannot be achieved satisfactorily for the infant or toddler in a natural environment” (IDEA, Public Law 108-446, Section 1400, 2004).

The notion of “social inclusion” is based on knowledge about the development of social behavior, which is extraordinarily complex. Fox and colleagues (1997) note that friendships and other relationships cannot be formed without potential partners, and comfort in social and public situations cannot be achieved without familiarization and repeated exposure. Learners with ASD can benefit from programs that are individualized, carefully planned and implemented, and that use naturalistic learning opportunities with typically developing peers. Such programs offer many opportunities for individuals with ASD to learn from typically developing peers and to practice new skills in a variety of settings (e.g., lunch, recess). Learning opportunities with typically developing peers in naturalistic settings are especially important for learners with ASD because they will be more likely to generalize skills to every day settings. To ensure that individuals with ASD are successfully included in least restrictive and natural environments, regular and special education teachers and other team members must form collaborative relationships to adapt and modify the curriculum, environment (e.g., use of visual supports), and communication/language used during interactions (e.g., use of simple language and gestures). Adaptations in curriculum, environment, communication/language, and activities are needed for successful inclusion.

The belief that learners with ASD are best served in inclusive and least restrictive environments is supported by the National Research Council’s (2001) statement regarding educational placements: “to the extent that it leads to the specified educational goals (e.g., peer interaction skills, independent participation in regular education), children should receive specialized instruction in settings in which ongoing interactions occur with typically developing children.” Individual skills should be targeted to provide optimum benefit from interactions with typically developing children and to provide the foundation for success in natural or inclusive settings.

Providing Access to the Curriculum and to the Community

To improve educational opportunities and outcomes, children with disabilities must have access to the general curriculum. IDEA (2004) requires public schools to provide free and appropriate public education to children with disabilities, as well as access to the general curriculum. According to IDEA regulations, the term *general curriculum* means the same curriculum as that established for students without disabilities (Assistance to States for the Education of Children With Disabilities and Preschool Grants for Children With Disabilities; Final Rule, 34 C.F.R. § 300-301, 2006). The specific content of the general curriculum is influenced to a great extent by national, state, and local standards.

IDEA supports access to the general curriculum by requiring that: (1) IEP goals must address how the student will be involved in and progress in the general curriculum; (2) the IEP must specify needed aids and services, accommodations, modifications, or supports required to facilitate access to the general curriculum; and (3) the IEP must include an explanation if the student will not participate in the regular classroom.

The Access Center, funded by the Office of Special Education Programs, U.S. Department of Special Education, proposes that “access to the general education curriculum occurs when students with disabilities are actively engaged in learning the content and skills that define the general education curriculum” (The Access Center, n.d.). For this to occur, the following should be in place:

1. ensuring that the general education curriculum is using “appropriate, standards-based instructional and learning goals for individual students with disabilities, including appropriate scope and sequence”;
2. using appropriate research-based and proven instructional methods and practices for assisting students with disabilities to learn the general education content and skills;
3. using appropriate research-based materials and media that have evidence that documents their effectiveness in helping students with disabilities learn general education content and skills;
4. using research-based supports and accommodations that have been shown to help students with disabilities learn general education content and skills; and
5. using appropriate tools and procedures for *assessing* and documenting whether students with disabilities are meeting high standards and achieving their instructional goals (The Access Center, n.d.).

In addition to providing access to the general curriculum, all children with disabilities must have access to a free appropriate public education (FAPE) that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living (IDEA, 2004). This includes, for example, skills needed for transitioning to future educational environments, functional skills needed for employment and other adult living activities such as daily living skills, and skills necessary to have access to the community (IDEA, 2004).

Planning for Transitions

Many individuals with ASD have difficulty with change. In fact, the development of routines, insistence on sameness, and difficulty with transitions are characteristics associated with autism. Team members must be mindful of these tendencies when preparing learners for fluctuations in everyday routines, and understand that planning for transitions among programs (e.g., early intervention to preschool, then to kindergarten, to elementary school, to middle and high school, and to community and/or work) requires collaboration, preparation, and time.

As Dawson and Osterling (1997) highlighted in their review of the core features of successful early intervention programs for learners with autism, it is crucial that individuals learn the skills needed for success in future settings. The specific skills will

vary by age, developmental level, and settings. For example, a young learner who will be moving from a preschool to a mainstream kindergarten will need to know how to line up with peers, how to sit at a table, how to take off his or her coat and hang it up. An adolescent who is moving from high school to college will need to be able to self-advocate with advisors and professors in order to access accommodations at the college level. Planning for these transitions should start early.

A more detailed discussion of programmatic transitions (e.g., from one educational program to another or from educational programs to post-secondary community settings) is provided later in this course.

Embracing a Systems Approach

Fullan (1991, 2001) described the introduction of new practices or techniques, such as the use of evidence-based practices, as “innovations” to a system and proposed that one factor that promotes the successful introduction of innovations is to have an external agent assist with its initiation. Knowledge about autism and about EBP is not enough to ensure the successful implementation of practices.

Team members who identify appropriate EBP for achieving IFSP/IEP goals and objectives and then implement them do not work in a vacuum. They must have the support of principals or other supervisors, family members, their peers, and the other members of their interdisciplinary team. In the school building, both teachers and principals must collaborate with special education directors or other supervisors at the district level to obtain their support for the use of EBP. Within the early intervention community, team members across many systems need to effectively collaborate in order for families to feel supported. Consistent intervention is a team endeavor. Families must support the use of these innovative EBP with their toddlers and children. Ideally, all team members who serve learners with ASD currently or in the future need to embrace the use of EBP across age and grade levels to promote the optimal development and learning of learners with ASD and to prepare them to live and work independently in community settings as they transition to adulthood.

For these reasons, the National Professional Development Center on ASD selects states as collaborative partners that are eager to embrace EBP at the systems level. Ideally, local practitioners and early interventionists, teachers and their principals and supervisors; all members of interdisciplinary teams; local, district, and state agencies and advocacy groups; and families will support the use of EBP so that it becomes sustainable even after involvement with our project ends.

In order to effectively implement EBP, training, ongoing support, and evaluation are three of the six critical core implementation components required to successfully adopt an innovation. The other core components are staff selection, facilitative administrative support, and systems interventions (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005;

Fixsen, Naoom, Blasé, & Wallace, 2007). So, in addition to team members, school and system-level administrators are needed to create and develop the climate and leadership needed to facilitate the implementation of EBP in your state.

Organizational Components

Organizational components have an impact on the success of implementing a new practice or learning. Organizational components or factors include the early intervention program, the school building, school district, and other infrastructures that may support (or challenge) the implementation. Decisions about staffing resources, about the provision of training and ongoing consultation, and about evaluation are examples of organizational decisions that influence the implementation of innovative practices.

Influence Factors

In addition, social, economic or political influence factors such as state and federal policies may directly or indirectly influence the use of EBP. Federal initiatives (e.g., IDEA 2004; Combating Autism Act of 2006; No Child Left Behind), state appropriations, and governors' initiatives, such as state commissions on autism that fund and support training and implementation of EBP for learners with autism, are examples of political and economic influence factors.

By understanding this multi-level approach to change, practitioners can appreciate how difficult it is to implement innovation within existing organizations, including schools and early intervention programs, to change practice, sustain the change, and support it across systems.

Team members do not work in isolation. For evidence-based practices to be implemented consistently within an early intervention or school system on an ongoing basis, practitioners need the support of families, administrators principals, special education directors, and advocates. This commitment to providing services that have been proven to be effective should improve the lives of learners with ASD and their families.

Session 4 Guiding Principles

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Discussion Questions

Session 4: Discussion - Providing Services in Natural (or Naturalistic) and Least Restrictive Environments

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Describe some of the ways in which IDEA supports access to the general education curriculum for learners with ASD?

Session 4: Discussion - Providing Family-centered Support and Honoring Diversity

Describe some of the reasons it is important to use a family-centered approach for effective intervention and education of learners with ASD?

Session 4: Discussion – Embracing a Systems Approach

In your experience, what system-level components have you found to be necessary for successful implementation of EBP's within the early intervention system? Within school systems?