



Cumann Síceolaithe Éireann

Professional Practice Guidelines for the Assessment, Formulation, and Diagnosis of Autism in Children and Adolescents, 2nd Edition

Special Interest Group in Autism
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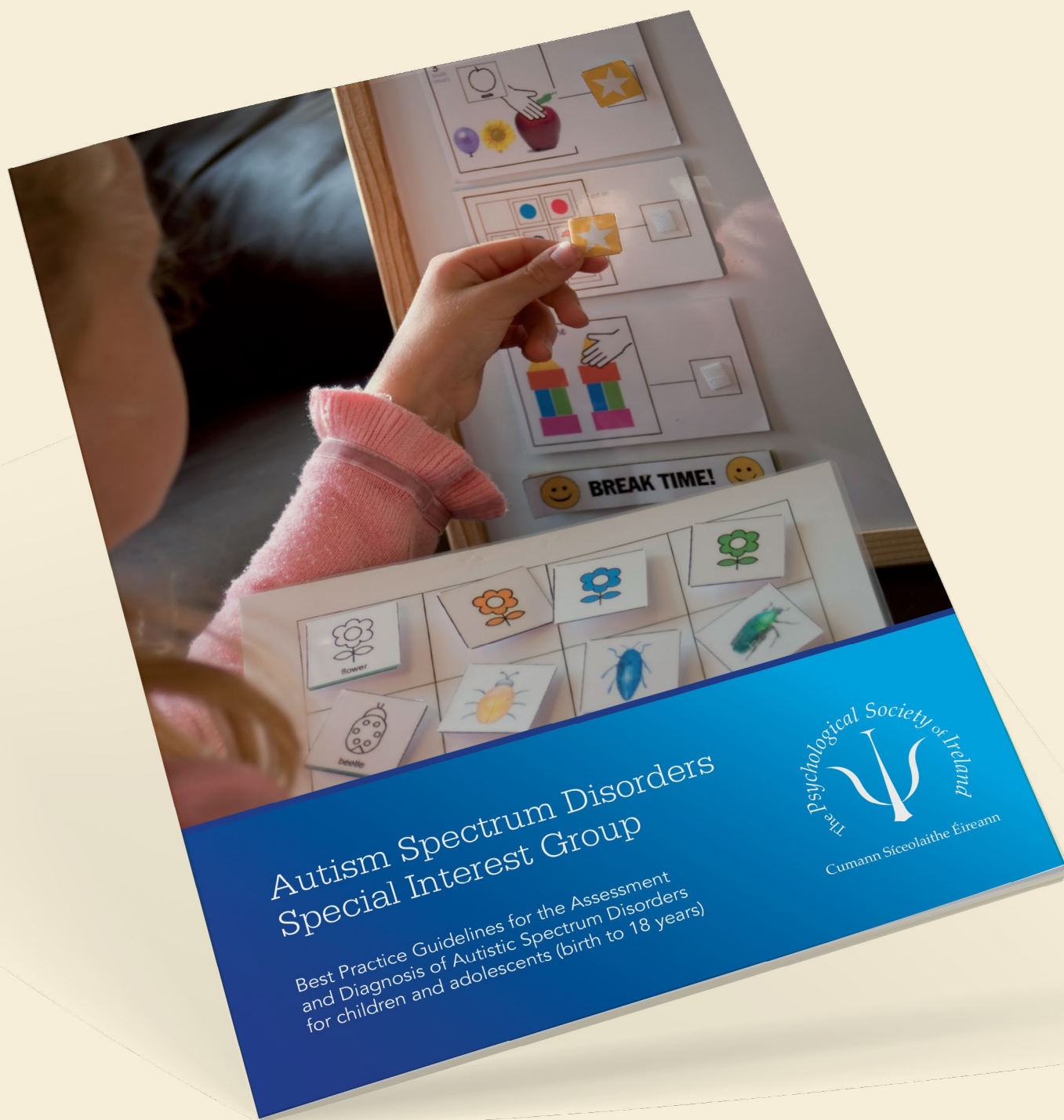
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Produced in 2010, the Psychological Society of Ireland's *Best Practice Guidelines for the Assessment and Diagnosis of Autism Spectrum Disorders for Children and Adolescents (birth to 18 years)* laid the foundations for the 2022 edition



INTRODUCTION

Preface

Autism is a lifelong neurodevelopmental condition that is characterised by differences in social communication and social interaction, restricted and repetitive patterns of behaviours and interests, and sensory processing differences. Over recent years there has been a rapid evolution in our conceptualisation of autism. Happé and Frith (2020) summarise these changes and note that “the traditional notion that autism is a disorder defined purely by deficits inherent to the person has been challenged”. Those who embrace the neurodiversity paradigm propose that autism is considered a difference that constitutes a disability in the context of the demands of the neurotypical world. There is no universally accepted approach for diagnosis of autism, although there is broad agreement about what constitutes good practice. This includes adherence to international classification systems; selection, use and interpretation of standardised measures; the key role of experienced clinical judgement; and a team approach. The challenge for psychologists is to deliver high quality assessments, tailored to meet the individual needs of each child and family, informed by research evidence on the accuracy of assessment tools, with a view to informing clinical judgement, psychological formulation, and a robust diagnostic process. The process of each autism assessment involves taking time to achieve a comprehensive understanding of the child with a view to planning for future support needs. These *Professional Practice Guidelines for the Assessment, Formulation, and Diagnosis of Autism in Children and Adolescents* were developed to promote proficiency and to help facilitate a high level of professional practice by psychologists.

From this point forward, the *Professional Practice Guidelines for the Assessment, Formulation, and Diagnosis of Autism in Children and Adolescents, 2nd edition*, will be referred to as the “2022 Guidelines” where the full document title is not used, and the 2010 *Best Practice Guidelines for the Assessment and Diagnosis of Autism Spectrum Disorders for Children and Adolescents (birth to 18 years)* will be referred to as the “2010 Guidelines”

Acknowledgements

These 2022 Guidelines were developed over a three-year process, led by a working group from the committee of the Special Interest Group in Autism (SIGA), including autistic psychologists, and in consultation with the broader membership of the Psychological Society of Ireland (PSI).

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Distinguishing between professional practice guidelines, clinical practice guidelines, and standards

Guidelines are statements that suggest or recommend specific professional behaviours, activities, endeavours, approaches, or conduct for psychologists American Psychological Association (2015). Guidelines are aspirational and promote the systematic development of the profession. Professional practice guidelines are developed based on consensus within the profession and differ from clinical guidelines that rely on systematic reviews of the literature. Professional practice guidelines incorporate evidence-informed and values-based practices. In contrast, *standards* are mandatory and may be accompanied by an enforcement mechanism (e.g., PSI *Code of Professional Ethics*, 4th Edition, 2019).



Need for updated guidelines

In 2010, the PSI first published *Best Practice Guidelines for the Assessment and Diagnosis of Autistic Spectrum Disorders for Children and Adolescents (birth to 18 years)*. The 2010 Guidelines were developed in response to the needs of members of the PSI. A revision of the 2010 Guidelines is warranted at this time as psychological research and practice in autism assessment and diagnosis have evolved. Research suggests that diagnostic procedures are not consistent across practice and that diagnostic rates can be affected by contextual and social drivers (Hayes et al., 2018). The 2022 Guidelines serve to update the 2010 Guidelines based on recent research and emerging practice trends. In the 2022 update, each guideline includes a rationale section that provides content relevant to the guideline topic and an application section that provides recommendations for psychologists to follow in clinical practice.

Substantive changes from the 2010 Guidelines include incorporating a degree of flexibility in relation to the essential components of the assessment process to ensure that individual needs are met (Hayes et al., 2018; Penner et al., 2018). In addition, while a review of a child's past and current medical history is deemed essential, the 2022 Guidelines no longer recommend that medical evaluation forms part of the assessment process, unless this is clinically indicated.

Since the publication of the 2010 Guidelines the landscape of autism awareness, understanding, research, and practice has changed considerably, both internationally and within the Irish context. These changes are outlined here to demonstrate the need for these updated guidelines. Please note that they are more comprehensively described in a paper by Happé & Frith (2020).

1. Changes to diagnostic criteria

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR; American Psychiatric Association, 2022) and the 11th edition of the International Classification of Diseases (ICD-11; World Health Organization, 2019) specify one broad category for autism,

labelled *autism spectrum disorder*. This contrasts with previous narrow definitions of autism with adjunctive sub-classifications (including Asperger's syndrome, pervasive developmental disorder-not otherwise specified, and childhood disintegrative disorder). Classification of autism in DSM-5-TR and ICD-11 helps to harmonise diagnosis. However, diagnosis, of itself, does not establish the kinds of supports required, and hence, clinical diagnosis should be personalised and contextualised, focusing on both individual limitations and strengths.

2. Changes in public and professional awareness of autism

Over the past 10 years there has been a radical and dramatic rise in public and professional discourse about autism, leading to increased awareness and recognition of autistic children and adolescents. Prevalence studies indicate that autism, once a rare diagnosis, is now recognised as relatively common. This has resulted in an exponential increase in referrals for autism assessment and diagnosis (Russell et al., 2022).

3. Diagnostic substitution

Research suggests that as autism diagnoses have increased, diagnoses of developmental language disorder and intellectual disability have declined. Children and adolescents who may previously have received a primary diagnosis of intellectual disability may now be more likely to receive a diagnosis of autism (Bishop, Whitehouse, Watt & Line, 2008; Shattuck, 2006; Coo et al., 2008).

4. Lifelong trajectory

Autism was previously characterised as a childhood diagnosis with uncertain prognosis. It has since been recognised that autism is a lifelong neurodevelopmental condition. There is a generation of autistic adults who may not have received the diagnosis as children and who report negative quality of life outcomes. Receiving an accurate diagnosis of autism can be a positive, affirming, and supportive experience. In contrast, missed or misdiagnosis can have a negative impact on a child's future and is not without significant risk (e.g., Kanne & Bishop, 2021).



5. From discrete to dimensional

Autism was previously understood as a single entity diagnosis. Some previous diagnostic systems excluded co-occurring diagnoses or conditions. It is now well recognised that autism is present across all ages, levels of language and cognitive ability, within a broad range of genetic conditions, alongside other difficulties including epilepsy, sleep disorders, gastrointestinal issues, and mental health or behavioural concerns. This complexity of presentation requires experienced clinical judgement.

6. Heterogeneity

With such a broad diagnostic classification of autism, often accompanied by a range of co-occurring difficulties, there is an emerging recognition of the heterogeneity of autism. It could be argued that there is as much individual difference and diversity among autistic children as there is among non-autistic children. Such variability in presentation requires a level of flexibility in individualising autism assessments and supports to meet the needs of each child and family, as opposed to a standardised “one-size-fits-all” pathway.

7. Cultural validity of assessment measures

In the past, most of those referred for autism assessment had similar demographic profiles, but increasingly referrals are made for children from a wide range of backgrounds. In this context, it is necessary to revisit the effectiveness and evidence base for the use of different measures, and to consider the most effective way to assess children from different backgrounds.

There are many different measures available for screening, diagnosis, and assessment in autism, and such assessment measures are essential for identifying individual characteristics and support needs. Nevertheless, there is a need to demonstrate the validity and reliability of these instruments for economically or socially disadvantaged groups, ethnic or racial minorities, or for individuals with co-occurring conditions.

8. Needs-led supports

Access to resources has arguably been a significant motivation for early diagnosis of autism. Research has

indicated that clinicians sometimes err on the side of positive diagnosis of autism when they are less than certain (Skellern et al., 2005; Rogers et al., 2016). This may occur as a strategy to facilitate a child's access to resources that demand a categorical diagnosis, which has clear ethical implications. Fortunately, there is an emerging move away from diagnosis-led access to health and education supports and services in favour of needs-led supports. This will require assessments to look beyond the diagnostic label to provide meaningful understanding of each child's profile of strengths, differences, and needs.

9. From “disorder” to neurodivergence

The historical categorisation of autism as a “disorder” necessitated evidence of significant impairments in daily life. With the emerging neurodiversity paradigm and the social model of disability, it is recognised that autism can result in fluctuating levels of disability depending on the demands of the neurotypical world and available environmental supports. This conceptualisation poses challenges for traditional assessment and diagnostic approaches.

It can be argued that in this rapidly evolving field there is now an even greater onus on psychologists to acquire and maintain competency in assessing children and adolescents with a broad range of ages, communication abilities, cognitive profiles, and life histories to allow for accurate, flexible, and timely assessment, formulation, and diagnosis. These updated professional practice guidelines serve to support evolving professional practice considering these contextual changes.

Professional ethics, competency, and avoidance of harm

Psychologists benefit from adherence to professional practice guidelines to maintain competency expectations and to avoid harm. Professional practice guidelines define good practice for psychologists at all stages of their training and career trajectory. The 2022 Guidelines offer guidance for decision making and are intended to be read in conjunction with the PSI *Code of Professional Ethics*, 4th Edition (2019).



There is an ethical responsibility for psychologists engaged in assessment and diagnosis of autism to have the prerequisite training and supervised experience; competency in administration and interpretation of psychometric tests, psychological formulation, and differential diagnosis; and knowledge of frequently co-occurring conditions. In line with *PSI Supervision Guidelines for Psychologists* (2017), psychologists engage in continuing professional development and reflective supervision, consider advances in the evidence base, and recognise the limits of their competence. Developing and maintaining competence in assessment and diagnosis of autism is an evolving process. Clinical judgement is one important aspect of competence, and is developed over time through experience, practice, knowledge and continued critical analysis and communication within the profession (Kienle & Kiene, 2011).

Psychologists providing assessment, formulation, and diagnosis of autism make decisions about children and adolescents that may have a profound impact on their life trajectory. If misdiagnosed, the child may be excluded from needed services or inaccurate expectations may be formed about that child's future. Even if the diagnosis is correct, a poor-quality assessment can have negative consequences by providing insufficient information about the next steps (Kanne & Bishop, 2021). Professional practice guidelines support psychologists in decision-making and raise awareness of potential personal or situational biases that can result in sub-optimal decision making and harmful outcomes.

A note on language

The 2022 Guidelines posit that autistic people may navigate some parts of life differently, rather than being individuals whose experiences are solely understood and captured as clusters of deficits. Whilst *autism spectrum disorder* is the term used in current diagnostic manuals, throughout this document children and adolescents are referred to as *autistic* rather than *children/adolescents with autism*, as per National Institute for Health and Care Excellence (NICE) updates published in June 2021.



THE BASIS OF THE PROFESSIONAL PRACTICE GUIDELINES

By definition, professional practice guidelines guide practice. The need for guidelines might be less if autism assessments were simple and straightforward. However, as noted throughout this document, the complexity of autism assessments varies considerably, the stakes are high, and assessment has changed in recent years as the profiles of those referred for autism assessment have become more diverse and as our knowledge and understanding of autism has expanded.

Just as the process of autism assessment is complex, so too is the interplay of influences on the practice of autism assessment. Professional practice guidelines do not rely on a single source of information. Rather, they reflect a diverse range of factors that are important to consider in one's practice. The following procedural guidelines and additional considerations discussed are evidence informed and grounded in a wide range of information, values, and perspectives that relate to the assessment of autism. The various underpinnings of the guidelines are described over the following pages.

1. Previous guidelines

For over ten years, psychologists in Ireland have been guided by the PSI 2010 Guidelines on autism assessment, which provided a systematic and coherent framework for conducting autism assessments. The 2010 Guidelines focused on producing a profile of strengths and needs leading to socially significant intervention planning, not solely assigning a diagnostic label. The 2022 Guidelines are informed in part by the 2010 Guidelines. They are also informed by international clinical guidelines, including NICE and the Scottish Intercollegiate Guidelines Network (SIGN), that provide important information and perspectives. During the development process, similarities and differences were noted in the content of the international guidelines, and consideration was given to published evidence for and against their use in different circumstances.

2. Rights

The 2022 Guidelines were developed in the context of international agreements and Irish legislation related to the rights of children and individuals with disabilities. In 1992, Ireland ratified the United Nations (UN) *Convention on the Rights of the Child* (1989) and, in 2018, Ireland ratified the UN *Convention on the Rights of Persons with Disabilities* (2007). In doing so, Ireland committed to promoting, protecting and ensuring the rights of children and young people. Irish legislation such as the *Health Act* (2007), the *Disability Act* (2005), and the *Education Act* (1998) further establishes this commitment and has informed the development of the 2022 Guidelines.

3. Current Irish context

The 2022 Guidelines were developed in the context of policy changes that are taking place in Ireland. In the health services, *Progressing Disability Services (PDS)* is changing the way services are provided. One of the main principles underpinning the *National Policy on Access to Services for Children & Young People with Disability & Developmental Delay* (HSE, 2019) is that access to services is needs-led rather than diagnosis-led. In primary and secondary schools, children and young people no longer need an autism diagnosis to access additional teaching time in school. There are plans for Special Needs Assistant (SNA) allocations to follow a similar approach. These changes are in their infancy and will take time to fully implement. Although autism assessment will remain of value, it is likely that over time diagnosis will be less important to access services and supports.

4. Perspectives of parents

These guidelines are based in part on research findings exploring parents' experiences of autism assessment and diagnosis. International and Irish studies highlight parents' descriptions of a stressful and confusing process, both prior to and following diagnosis. Some parents of children who fall outside the most prevalent demographics for



autism referral described especially confusing and lengthy pathways to diagnosis. Specific concerns include:

- being prepared for the assessment process
- the length of time an assessment may take
- accessing post-assessment information and support
- lack of expertise of some professionals in autism diagnosis
- feedback sessions and/or reports that include either too much or too little information

Research also describes some parent preferences, including:

- a strengths-based approach highlighting positive attributes about their children
- optimistic statements about prognosis and intervention that preserve hope
- information and recommendations that are tailored to the specific needs of their child, as opposed to more generic information on autism

It is hoped that these 2022 Guidelines address the concerns and preferences reported by families by promoting a high level of proficiency, flexibility, and responsiveness in the professional practice of autism assessment.

5. Perspective of autistic people

Accounts of lived experience are increasingly influential in informing professional practices. The current guidelines are informed by an awareness and knowledge of first-person narrative accounts of autistic people and the evolution of the neurodiversity paradigm. Consideration was given to public statements and voices of autistic adults, and the views of autistic psychologists on the working group that developed these practice guidelines.

6. Clinical experience

Expert professional consensus is considered one of the strongest forms of evidence for good practice (APA, 2015) and may be derived from a number of sources. During the development of the current guidelines, professional consensus was sought in various ways:

- During the early stages of updating the 2010 Guidelines, far-reaching and extensive clinical discussion was held within the Special Interest Group in Autism about all aspects of autism assessment.
- An earlier draft of these guidelines was sent for comment to a wide group of psychologists, including those working in public, private, and academic settings. Submissions were reviewed, and feedback informed the final document.
- Published opinions of international experts in autism assessment were considered.
- Each of the 37 guidelines and 7 considerations within this document was discussed, debated, and agreed by psychologists who brought their wealth of experience in autism assessment to the process.

These guidelines have been strengthened by the clinical experience and expertise of all of those who contributed.

7. Values-based practice

When developing these professional practice guidelines, the working group participated in an ongoing process of values clarification. Values guide evolving psychological practices, providing a constant sense of direction. Values are chosen concepts linked with patterns of action that provide a sense of meaning (Dahl et al, 2009). Values, as well as evidence, underpin all decisions. Values-based practice is fully complementary to and supports evidence-based practice. Within this subsection of the document, the pronoun “we” is used as a shorthand to reflect the consensus values and opinions of the working group. Some shared values guiding these professional practice guidelines include:

Respect for human rights

Respect for the rights and dignity of the child and family. In accordance with the UN Convention on the Rights of Persons with Disabilities (CRPD), each child and family is shown respect and granted dignity as part of their common humanity. We practice with sensitivity to cultural, social, and neurological diversity. We appreciate the need for child and family centred practice and avoid an adherence to a “one-size-fits-all” framework.



Autonomy

We value and support the autonomy and self-determination of the child and family throughout the assessment process.

Strengths-based approach

We approach autism assessments with a focus on collaboratively identifying strengths, individual differences, natural supports, and reasonable accommodations that enable us to meet the needs of each child and family.

Curiosity

We value an open-minded and curious approach to assessment, promoting consideration of alternative explanations and new possibilities. Cultivating curiosity encourages deep understanding, careful listening, and an empathic approach.

8. Targeted seminal and recent research evidence

The research cited in the current guidelines is not intended to serve as a comprehensive systematic review of the literature. Instead, research findings are included in a targeted way that informs these practice guidelines where necessary. Some of these practice guidelines were developed in response to new research that has changed our understanding of autism assessment in important ways. Other guidelines refer to long established research findings. Both seminal studies and targeted reviews of current research are considered throughout these guidelines and can be found in the references section and bibliography.



SUMMARY OF THE PROCEDURAL GUIDELINES

PROCEDURAL GUIDELINES: Multiple components of assessment

Guideline 1. Autism assessments have multiple components.

Guideline 2. The number and types of sources of information considered during assessment are based on individual clinical considerations as part of flexible and reflective practice.

Guideline 3. Standardised diagnostic measures are used as a structured way of collecting clinical data, but not as a stand-alone determination of outcome.

Guideline 4. All components of the assessment are developmentally appropriate and are child- and family-centred.

Guideline 5. Sufficient time is taken and additional assessment measures are used as needed when a child has a complex presentation.

PROCEDURAL GUIDELINES: Referral information

Guideline 6. Adequate referral information is sourced and reviewed prior to planning and contracting for the autism assessment.

Guideline 7. Referral information includes specific information including the source of the referral information, the nature of the concerns, strengths and interests of the child, and contextual information.

PROCEDURAL GUIDELINES: Assessment planning and contracting

Guideline 8. The psychologist talks with the parents/guardians and the young person as appropriate prior to commencing the assessment to achieve a shared understanding of the goals and processes of the assessment and informed consent/assent.

PROCEDURAL GUIDELINES: Screening measures

Guideline 9. Screening measures are only used when they add useful information to the assessment of autism. When

they are used, it is with caution and in combination with other sources of information.

Guideline 10. The psychologist is aware of the most up-to-date research on the limitations in relation to validity, sensitivity, and specificity of any screening measures that are used.

Guideline 11. Screening measures are not used in isolation to determine whether further assessment of possible autism is indicated.

Guideline 12. Screening measures are not used to diagnose autism.

Guideline 13. Support is offered to those completing screening measures as needed.

PROCEDURAL GUIDELINES: Medical history and current medical concerns

Guideline 14. Information about the medical history of the child and family members is reviewed as part of the assessment and formulation.

Guideline 15. Referrals to a paediatrician or to another medical professional are made if indicated, based on clinical judgment, the physical presentation of the child, and indications of medical/health concerns.

PROCEDURAL GUIDELINES: Developmental, family, and clinical history

Guideline 16. A general developmental history, family history, and history of clinical concerns is taken prior to commencing any autism-specific assessment measures.

Guideline 17. Both of the child's parents/guardians participate in the developmental interview if possible.

PROCEDURAL GUIDELINES: Assessment of autism-specific diagnostic criteria

Guideline 18. The psychologist refers to an established classification system such as DSM-5 or ICD-11 to guide the information-gathering process.



Guideline 19. The psychologist interacts with and observes the child as part of the autism assessment.

Guideline 20. Direct observations take place across two or more settings, including a clinic setting and a non-clinic setting such as school, preschool, or home.

Guideline 21. Both structured and naturalistic observations of the child are conducted.

Guideline 22. The autism assessment includes information about the child's presentation in different settings provided by parents, teachers, and others who know the child well.

Guideline 23. The autism assessment includes information about early developmental history as well as current presentation.

PROCEDURAL GUIDELINES: Formulation

Guideline 24. Team and/or psychological formulation is an integral part of an autism assessment.

Guideline 25. The psychologist is central to the formulation process.

PROCEDURAL GUIDELINES: Consideration of alternative and additional explanations

Guideline 26. The psychologist considers alternative explanations for the child's presentation, including differential diagnosis and psychosocial influences.

Guideline 27. When assessment supports a diagnosis of autism, the psychologist also considers co-occurring conditions.

Guideline 28. The psychologist acquires and maintains up-to-date knowledge and experience with a broad range of presentations so as to reliably consider alternative or additional explanations.

PROCEDURAL GUIDELINES: Report writing

Guideline 29. A comprehensive written report outlining the assessment process, findings, formulation, diagnostic outcome, and recommendations is shared with the family by the time of the final feedback session.

Guideline 30. Parents/guardians are given the opportunity to discuss the report and amend any incorrect information before the report is finalised and shared.

Guideline 31. Reports are written in clear language that is easily understood by the family.

Guideline 32. The diagnostic outcome of the assessment is clearly stated in the report and falls into one of the following categories:

- Assessment supports a diagnosis of autism, with or without co-occurring diagnoses or conditions.
- Assessment does not support a diagnosis of autism, and an alternative formulation is provided.
- No conclusion can be drawn about an autism diagnosis at this time. A specified period of intervention and/or watchful waiting is recommended. In this case, a recommendation for follow-up is included in the report.

PROCEDURAL GUIDELINES: Feedback

Guideline 33. Formal feedback sessions are the culmination of on-going communication with parents/guardians throughout the assessment process.

Guideline 34. Parents/guardians are offered one or more formal face-to-face feedback sessions in a timely manner following completion of the assessment.

Guideline 35. When an adolescent or older child has undergone an assessment, consideration is given to providing direct feedback to the young person.

Guideline 36. Feedback is clear, concise, and compassionate and includes clinical formulation in relation to the child's presentation, strengths, and areas of difficulty, whether or not the assessment supports a diagnosis of autism.

Guideline 37. Feedback includes individualised recommendations for supporting the specific needs of the child and family.



PROCEDURAL GUIDELINES FOR AUTISM ASSESSMENT

Multiple Components of Assessment

Guideline 1. Autism assessments have multiple components, including but not limited to:

- review of referral information
- assessment planning and contracting
- information about medical history and current medical concerns
- comprehensive review of developmental and clinical history
- information about family context and history, including relationships/attachment
- information about emotional, behavioural, and mental health needs
- information about strengths and interests
- information about the child's developmental level and/or cognitive ability, and adaptive functioning
- assessment of autism-specific diagnostic criteria, i.e., social communication, social functioning, restricted and repetitive behaviours and interests, and sensory differences
- team and/or psychological formulation
- consideration of alternative and additional explanations for presentation
- report writing
- feedback to parents/guardians and to the young person, when appropriate

Guideline 2. The number and types of sources of information considered during assessment are based on individual clinical considerations as part of flexible and reflective practice.

Guideline 3. Standardised diagnostic measures are used as a structured way of collecting clinical data, but not as a stand-alone determination of outcome.

Guideline 4. All components of the assessment are developmentally appropriate and are child- and family-centred.

Guideline 5. Sufficient time is taken, and additional assessment measures are used as needed when a child has a complex presentation.

Rationale: Guidelines on multiple components of assessment

Inclusion of multiple components provides converging evidence to support the diagnostic conclusion and clinical formulation. This is crucial to reduce the risk of both false positive diagnoses (when a person who is not autistic is given a diagnosis of autism) and false negatives (when an autistic person is not given a diagnosis of autism), and the associated potential negative impact on children, families, and services.

Inclusion of multiple assessment components facilitates differential diagnosis and identification of co-occurring conditions. The use of multiple assessment components also allows the identification of the child's strengths and needs, as well as the supports that would enable them to make progress towards identified goals.

All psychologists benefit from the use of standardised measures when assessing children and young people and the use of these measures is recommended unless there is a clear clinical rationale to consider other means of gathering necessary information. Standardised interviews and observations (such as the Autism Diagnostic Interview-Revised (ADI-R; Lord et al., 1994), Autism Diagnostic Observation Schedule, Second Edition, (ADOS-2; Lord et al., 2012), Diagnostic Interview for Social and Communication Disorders (DISCO; Wing et al., 2002) and other standardised measures) are helpful for gathering baseline information, especially in complex presentations. In addition, regular and repeated use of standardised measures supports clinicians to develop competency and expertise across a broad range of presentations of autism. Using standardised diagnostic measures protects and



controls against clinical judgement becoming biased in one direction or the other over time.

Guideline application

Selection of specific components of the assessment process should be individualised depending on the referral question, the child's presentation, and the level and type of experience of the psychologist. In some situations, a psychologist may reach a conclusion using fewer sources of information, and in other situations they may require more or different sources of information.

Examples of complex elements that may require more time and consideration include (but are not limited to):

- significant medical history
- environmental stress
- history of or current trauma
- co-occurring conditions
- multiple past assessments
- adverse childhood experiences (ACEs)
- children in overlooked populations
- children who have subtle presentations

Information about the child's developmental level and/or cognitive ability; adaptive functioning; and emotional, behavioural, and mental health needs may be assessed directly, or may be gathered from previous reports and other sources of information.

Referral information

Guideline 6. Adequate referral information is sourced and reviewed prior to planning and contracting for the autism assessment.

Guideline 7. Referral information includes specific information including the source of the referral information, the nature of the concerns, strengths and interests of the child, and contextual information.

Rationale: Guidelines on referral information

Referral information and a clear referral question inform assessment planning, including the selection of the appropriate and necessary components needed to proceed with effective and efficient assessment.

Inadequate referral information may result in delay of the commencement or completion of assessment as additional information must be sought, and may impact on the accuracy of decision-making about whether to accept a referral or redirect the referral to another service. Inadequate referral information may increase the likelihood of inconclusive/inaccurate outcomes if relevant information is not made available to the assessors.

Guideline application

Referral information includes information about the following:

- The nature of autism-specific and other concerns, such as specific information about play skills, friendships, special interests, behaviour, emotional regulation, attention, etc. This information is most helpful when behavioural examples are included.
- Relevant contextual information, such as school information, medical conditions, family composition, etc.
- Information about the child's strengths, abilities, and interests.

Consultation with the referring professional and/or parents/guardians may be required to seek additional information or clarify the referral question. Children with complex presentations or histories may require more comprehensive referral information to ensure that all relevant background information is made known to the assessor, including previous reports and summaries of previous intervention.

Consideration may be given to providing potential referrers with information that would be helpful to consider prior to referring a child for autism assessment.



Assessment Planning and Contracting

Guideline 8. The psychologist talks with the parents/guardians and the young person as appropriate prior to commencing the assessment to achieve a shared understanding of the goals and processes of the assessment and informed consent/assent.

Rationale: Guidelines on assessment planning and contracting

Assessment contracting clarifies the understanding of the family and the psychologist about reasons for the referral; the assessment process, including the role of the psychologist and other clinicians as well as the role of the family and young person; the possible outcomes of diagnostic assessment; the risks and benefits of diagnoses; and possible alternatives to diagnostic assessment.

Guideline application

Psychologists have a responsibility to ensure consent is specific, informed, valid, and freely given. Psychologists understand informed consent to be an evolving process that begins at first contact and is revisited as necessary throughout the process. Discussions may include but are not limited to the following topics:

- What is autism?
- What do the family and the young person hope to get from the assessment?
- What are the potential diagnostic outcomes of the assessment? (See guideline 32)
- What are the implications of a potential diagnosis? Or equally, if a diagnosis is ruled out?
- What are the implications of a “strengths and needs” formulation as an alternative to a diagnosis?
- What does an autism assessment involve? How many sessions? Will there be a school/preschool visit?
- Do they have any questions?

Screening Measures

Guideline 9. Screening measures are only used when they add useful information to the assessment of autism. When they are used, it is with caution and in combination with other sources of information.

Guideline 10. The psychologist is aware of the most up-to-date research on the limitations in relation to validity, sensitivity, and specificity of any screening measures that are used.

Guideline 11. Screening measures are not used in isolation to determine whether further assessment of possible autism is indicated.

Guideline 12. Screening measures are not used to diagnose autism.

Guideline 13. Support is offered to those completing screening measures as needed.

Rationale: Guidelines on screening measures

In this document, the term *screening measures* refers to standardised published instruments that have been developed and normed for the purpose of identifying children who have characteristics that are associated with autism. The populations on which autism screening tools have been normed are limited in relation to diversity. In addition, screening measures are less accurate in the context of some family and environmental circumstances, especially if the child has a complex presentation in relation to a broad range of social, emotional, learning, and behavioural challenges.

Clinical cut-off points in screening measures do not have sufficient accuracy to be relied on as a sole determinant to diagnose autism or to exclude a child from further assessment where there are other clinical indicators. Screening measures are primarily useful for identifying areas of concern for further assessment.

Some people who are asked to complete screening measures may need support to understand the instructions and/or the questions.



Guideline application

If psychologists use screening measures, it is essential that they are well-informed about their validity. For example, the psychometric properties of sensitivity and specificity can be used to evaluate the accuracy of screening measures. Sensitivity is the number of true cases correctly identified by an instrument and 70-80% is considered an acceptable rate (Norris & Lecavalier, 2010). Specificity refers to the number of non-cases correctly identified; and 80% is considered acceptable (Norris & Lecavalier, 2010).

There are negative implications in using screening instruments with less than acceptable rates of sensitivity and specificity. Low sensitivity rates may result in delayed access to the initiation of early intervention (Kanne et al., 2018) or missed diagnoses. Low specificity rates may be associated with considerable emotional implications for families engaging in assessments for autism, as well as increasing costs and waiting lists for under-resourced services (Kanne et al., 2018) and potentially contributing to misdiagnoses. Research describes increased efficacy levels for certain screening measures when lower cut-offs are used with certain populations (e.g., young children); as well as the impact of certain respondent factors (e.g., level of education or knowledge of autism) on the validity of the results. It is essential that psychologists refer to independent research so that they can evaluate the effectiveness of any screening measures used.

When deciding whether or not to use screening measures, consideration should also be given to parental literacy, language barriers, parental readiness to consider possible features of autism in their child, and the potential emotional impact of completing screening measures. It may be decided not to use screening measures or to offer additional support. Additional support to complete screening measures may involve individual help completing the forms, contact information if they have questions about the form, clarification of written information, or the provision of emotional support as needed.

Medical history and current medical concerns

Guideline 14. Information about the medical history of the child and family members is reviewed as part of the assessment and formulation.

Guideline 15. Referrals to a paediatrician or to another medical professional are made if indicated, based on clinical judgement, the physical presentation of the child, and indications of medical/health concerns.

Rationale: Guidelines on medical history and current medical concerns

Family history of autism or other neurodevelopmental conditions increases the likelihood of autism which is relevant to diagnosis. Some treatable medical conditions and/or medications may explain or influence the child's presentation. Possible co-occurring medical conditions that are associated with autism would require intervention or referral.

Guideline application

It is important for the psychologist to be familiar with current research and recommendations in relation to medical conditions that are associated with or contraindicate autism. Examples of indicators that warrant a referral to a paediatrician include (but are not limited to):

- any form of developmental regression after the age of three
- regression in motor skills at any age
- concerns in relation to possible seizures
- concerns about possible developmental coordination disorder
- tic disorders
- concerns about possible genetic syndromes

Referrals to the child's GP or practice nurse should be considered in relation to other health concerns. Examples include but are not limited to constipation, eczema, restricted diet, sleep difficulties, etc.



Developmental, family, and clinical history

Guideline 16. A general developmental history, family history and history of clinical concerns is taken prior to commencing any autism-specific assessment measures.

Guideline 17. Both of the child's parents/guardians participate in the developmental interview if possible.

Rationale: Guidelines on developmental, family, and clinical history

Broad information about the child's past and current life circumstances provides context for concerns and is essential for differential diagnosis and formulation. In addition, it provides information about protective factors, resources, and the strengths and abilities of the child and family.

By having a broad understanding of the factors that contribute to a child's presentation, a psychologist remains curious and open to a range of explanations for the child's difficulties, which may or may not include autism.

Unless contraindicated, it is valuable to have the perspective of both parents so as to have the most complete information about the child's life experience. In addition, the involvement of both parents from the beginning of the assessment process allows for an incremental shared understanding of possible explanations for the child's history and current presentation.

Guideline application

The child's developmental, family, and clinical history may be gathered through review of records, including referral information and previous reports, and then expanded and confirmed through parental interview.

A biopsychosocial framework can guide the information-gathering process, and may signpost areas that require more detailed exploration.

Assessment of autism-specific diagnostic criteria

Guideline 18. The psychologist refers to an established classification system such as DSM-5 or ICD-11 to guide the information-gathering process.

Guideline 19. The psychologist interacts with and observes the child as part of the autism assessment.

Guideline 20. Direct observations take place across two or more settings, including a clinic setting and a non-clinic setting such as school, preschool, or home.

Guideline 21. Both structured and naturalistic observations of the child are conducted.

Guideline 22. The autism assessment includes information about the child's presentation in different settings provided by parents, teachers, and others who know the child well.

Guideline 23. The autism assessment includes information about early developmental history as well as current presentation.

Rationale: Guidelines on assessment of autism-specific diagnostic criteria

Direct observations and interviews with parents/guardians and teachers provide different types of information. Direct observations allow the psychologist to observe the child and assess their social communication, social interaction, and behaviour directly; including the presence of restricted and repetitive behaviours. A limitation of direct observation is that only a small sample of behaviour is observed.

Observation in a clinic setting allows the child to be seen in a novel environment, where they may not be able to rely on their usual strategies or supports and may display different behaviours. Structured observation in a clinic-based setting allows for standardisation of the assessment process. However, some children may react badly to unfamiliar environments making it difficult to draw conclusions about their behaviours. Observation



in naturalistic settings provides information about the child's everyday functioning, which informs formulation and recommendations for intervention and support. Observation in naturalistic settings also provides crucial information about peer interactions that cannot be directly observed in a clinic setting.

Observing the child in both naturalistic and clinic-based settings maximize opportunities for the child to display both strengths and challenges, which may present differently across settings.

Information reported by parents, teachers, and others who know the child well allows the psychologist to learn about the child's social communication, social interaction, and behaviour across a range of settings and times. A limitation of relying on the reports of others is that the information provided is subjective and may be specific to particular environments and influenced by the respondent's understanding of autism.

Using both direct observations and information reported by others allows for triangulation of data, i.e., collating information from the parent, teacher, and psychologist. It is helpful to include multiple perspectives on the child's presentation in order to guide formulation and intervention planning.

Information about early developmental history, including presence of neurodevelopmental differences, is required to make a diagnosis of autism. However, it must be noted that, in some cases, challenges may not be noticed until later childhood when environmental demands become more complex.

Guideline application

Standardised observation tools and standardised developmental interviews may be used to gather information about autism-specific characteristics and behaviours.

Where direct observations across settings are contraindicated, video footage of the child may contribute to observational information gathering.

Psychologists should be mindful that children with subtle presentations may be able to mask their differences during observations. Psychologists should ensure that sufficient information is gathered to support meaningful formulation.

Formulation

Guideline 24. Team and/or psychological formulation is an integral part of an autism assessment.

Guideline 25. The psychologist is central to the formulation process.

Rationale: Guidelines on formulation

While autistic children share core characteristics, a diagnosis of autism alone is not an adequate basis on which to identify a child's abilities, needs, and potential future pathways, or to plan effective supports and intervention. Diagnosis alone tells us little about the child and nothing about the context and impact of their differences and difficulties.

A formulation is "a process of on-going collaborative sense-making" (Baudinet et al., 2021). It can be best understood as a co-construction of the personal meaning of the child's life story. It is not about making an expert judgement, but about working closely with the child and family to develop a shared understanding, which is likely to evolve over time.

Formulation is not based on deficits, but also draws attention to talents and strengths. When the assessment indicates a diagnosis of autism, formulation provides a holistic understanding that cannot be found in diagnosis alone.

When the assessment does not support a diagnosis of autism, formulation provides a meaningful understanding of the challenges experienced by the child that led to the initial referral.

Formulation identifies barriers and possible pathways to reaching one's potential and can identify tailored supports beyond what would be identified from diagnosis alone.



Formulation amplifies the voices of the child and family, providing space for their concerns and perspectives in the assessment and the report. It validates the emotional experience of the child and family. Formulation facilitates self-understanding for young people, which is a primary purpose of autism assessment.

Assessment, diagnosis and formulation are core skills of professional psychologists and, on that basis, psychologists play a lead role in team formulation.

Guideline application

A comprehensive assessment brings together the views of the child, family, and professionals to reach a shared understanding of the child's needs, difficulties, strengths, and protective factors.

The key role of the psychologist is to ensure that the assessment and diagnostic process is psychologically informed.

Psychological formulation is constructed by the assessing psychologist and incorporates information and perspectives from multiple sources, including other disciplines. Team formulation also includes multiple perspectives and is co-constructed with the other clinicians involved in the assessment.

Consideration of alternative and additional explanations

Guideline 26. The psychologist considers alternative explanations for the child's presentation, including differential diagnosis and psychosocial influences.

Guideline 27. When assessment supports a diagnosis of autism, the psychologist also considers co-occurring conditions.

Guideline 28. The psychologist acquires and maintains up-to-date knowledge and experience with a broad range of presentations so as to reliably consider alternative or additional explanations.

Rationale: Guidelines on consideration of alternative and additional explanations

Differential diagnosis involves discriminating autism from other developmental, attachment, and mental health conditions that lead to developmental differences in the areas of communication, social interaction, play, interests, and motor behaviours. Where the child's difficulties can be better accounted for by alternative explanations and/or diagnoses, it is crucial to delineate between these to facilitate meaningful intervention planning and positive outcomes.

Autistic people experience significantly higher rates of co-occurring mental health difficulties and other neurodevelopmental differences (DeFilippis, 2018; Romero et al., 2016) and it is important that these are accurately identified.

Guideline application

Consideration should be given to other conditions as relevant, including mental health conditions, intellectual disability, stress and/or trauma, motor disorders, sensory impairments, behavioural issues, neurological conditions, and genetic conditions. These differential considerations and possible co-occurring conditions are not to be considered as exhaustive. Psychologists undertaking autism assessments are required to be familiar with the evidence base for co-occurring conditions and differential diagnosis. This includes seeking appropriate supervision and Continuing Professional Development (CPD) in the relevant areas.

Psychologists should be mindful of the risk of diagnostic overshadowing, in which a diagnosis of autism is overlooked in the presence of other conditions, or co-occurring conditions are overlooked in the presence of a diagnosis of autism.

In light of the complexity of an autism diagnostic assessment, the range of expertise and perspectives provided within experienced multidisciplinary teams can support consideration of differential diagnosis, alternative explanations, or co-occurring conditions.



Report writing

Guideline 29. A comprehensive written report outlining the assessment process, findings, formulation, diagnostic outcome, and recommendations is shared with the family by the time of the final feedback session.

Guideline 30. Parents/guardians are given the opportunity to discuss the report and amend any incorrect information before the report is finalised and shared.

Guideline 31. Reports are written in clear language that is easily understood by the family.

Guideline 32. The diagnostic outcome of the assessment is clearly stated in the report and falls into one of the following categories:

- Assessment supports a diagnosis of autism, with or without co-occurring diagnoses or conditions.
- Assessment does not support a diagnosis of autism, and an alternative formulation is provided.
- No conclusion can be drawn about an autism diagnosis at this time. A specified period of intervention and/or watchful waiting is recommended. In this case, a recommendation for follow-up is included in the report.

Rationale: Guidelines on report writing

Comprehensive report writing is central to the practice of psychology. Many parents/guardians and young people will only take in a portion of the verbal feedback. The written report provides a permanent source of information for families to answer questions they may have about the assessment process and results, diagnostic outcome, formulation, and strategies to support the child.

Timely comprehensive reports are also required for children and their families to access many services and supports following the assessment, in particular school accommodations. In some situations, it is not possible to reach a definite diagnostic conclusion for a child due to the complexity of the child's presentation and/or significant

inconsistencies in the assessment findings. In these situations, it is appropriate to defer diagnostic decision-making to allow for a specified period of intervention and/or watchful waiting.

Guideline application

All reports are written with confidentiality in mind and comply with all data protection laws.

Within the report, the referral question is clearly answered and the diagnostic outcome of the assessment is presented in a clear manner. The diagnostic outcome falls into one of the three categories outlined in guideline 32 and this is clearly indicated. The report also clearly identifies any co-occurring conditions.

If the outcome of the assessment does not indicate a diagnosis of autism, the report includes a formulation providing a helpful and personally meaningful explanation of the factors that contributed to the child's perceived difficulties, the strengths and resources of the child and family, and the supports that may be helpful to them.

If the assessment does not yield a diagnostic conclusion, the clinical reasoning for this and the timeframe for review are clearly specified.

A report includes the views and voices of parents, young people, and others who know the child well. Provision of a draft report prior to finalisation allows the parents to correct any factual inaccuracies or omissions. If parents/guardians disagree with the diagnostic conclusion of the assessment or other aspect of the report, the psychologist may note this in the report. However, this will not change the diagnostic conclusion.

Reports are written in clear language that is easily understood by the family and any technical terms are explained in the body of the report. In some cases, it may be deemed appropriate to write a separate summary report for the parents/guardians and/or young person to support their understanding of the main concepts in the full report and recommendations.



Feedback

Guideline 33. Formal feedback sessions are the culmination of on-going communication with parents/guardians throughout the assessment process.

Guideline 34. Parents/guardians are offered one or more formal face-to-face feedback sessions in a timely manner following completion of the assessment.

Guideline 35. When an adolescent or older child has undergone an assessment, consideration is given to providing direct feedback to the young person.

Guideline 36. Feedback is clear, concise, and compassionate and includes clinical formulation in relation to the child's presentation, strengths, and areas of difficulty, whether or not the assessment supports a diagnosis of autism.

Guideline 37. Feedback includes individualised recommendations for supporting the specific needs of the child and family.

Rationale: Guidelines on feedback.

On-going communication and feedback across the assessment, at a pace respectful of the individual family, enables parents/guardians to learn incrementally about their child's presentation. The purpose of the formal feedback meetings is for parents/guardians to gain a comprehensive understanding of the assessment findings, including diagnosis where appropriate. It is recommended that this information is shared as soon as possible to reduce parental anxiety and stress.

Feedback with an older child or adolescent as appropriate is important to allow them the opportunity to receive balanced information about the outcome of the assessment, ask questions, and seek clarification. Children aged 16 and over have a legal right to receive direct feedback on the assessment and outcome, but many younger children will also benefit.

Parental reactions to a diagnosis of autism at the point of disclosure are many and varied. Research indicates the significant and long-lasting impact on parents/

guardians of their experiences of receiving a diagnosis, including a potential impact on parental mental health and on their ongoing relationship with support services. The attuned responses of the psychologist may influence parental satisfaction with the diagnostic process. When parents/guardians feel heard and have confidence in the assessment process, they are more likely to assimilate the information presented.

Guideline application

The psychologist is directed to the Informing Families Guidelines (National Federation of Voluntary Bodies, 2007), which offer practice guidelines for delivering a diagnosis of developmental disability. Consideration should be given to the physical environment and to limiting the number of professionals in the room when providing feedback on the outcome of the diagnostic assessment. Many parents and young people benefit from more than one feedback session. This provides an opportunity to process, question, and understand the assessment outcome and recommendations.

When giving a diagnosis of autism, the diagnostic criteria used (i.e., DSM-5 or ICD-11) should be named. It is helpful to use parents' language and incorporate their comments and observations when offering feedback on the assessment outcome.

The feedback meeting focuses on both the child or young person's strengths and areas of difficulty. The feedback meeting includes formulation, diagnosis where appropriate, discussion of parental views, concrete information regarding supports, and individualised recommendations that are tailored to the particular child and family.

It is recommended that parents/guardians and young people are informed of sources of post-diagnostic support and information that they can access in the future. The future experiences of each autistic individual will vary due to multiple factors, including intellectual functioning and social support. The role of the psychologist is to guide parents/guardians with informed realistic expectations for their child/young person based on the assessment



findings, empirical literature, and clinical experience. This discussion should take into account the child's age and developmental level and offer hope in relation to the child's ongoing progress. The limitations of predictive conclusions regarding preschool cognitive measures may be highlighted as appropriate.

Providing attuned emotional support is a key role of the psychologist during formal feedback sessions. This requires an awareness of the parents' and young person's emotional reactions to feedback on the assessment outcome, regardless of whether or not a diagnosis of autism is given. Responses to feedback are highly varied and mixed, as some people feel relieved and understood, and/or have feelings of worry, shock, grief, or anger. It is helpful to ask parents/guardians and young people directly about their experience of the assessment process and outcome.



ADDITIONAL CONSIDERATIONS

This section highlights a number of groups and topics for special consideration. Detailed exploration of these areas is outside the scope of these guidelines, and it is important that the psychologist familiarises themselves with the current literature and evidence base when working with specific groups.

Babies and toddlers

At present, the minimum age at which autism can be reliably diagnosed is not clear (SIGN, 2016). Psychologists who carry out assessments with infants should be thoroughly familiar with typical and atypical development and should proceed with caution in terms of early diagnosis. For example, at very young ages, it may be difficult to distinguish between autism-related differences and global developmental delay. A broad knowledge of infant mental health and various presentations and difficulties which can occur during infancy is essential.

Older children and adolescents

Psychological assessments of older children and adolescents may be complicated by variability in presentation of autism, presence of co-occurring conditions, and the intersectional influence of facets such as race, gender, or sexuality. Autism assessments for adolescents are often more complex and may take more time than assessments for younger children. Older children and adolescents who are referred later often have more complex or subtle presentations that require careful consideration, including in relation to differential diagnosis or co-occurring conditions. It may be challenging to determine whether issues such as anxiety and internal distress, loneliness, low mood, or other concerns are related to autism, or if they are due to other underlying conditions such as mental health difficulties.

The use of self-report measures and clinical interviews with the child may be considered when assessing older children and adolescents. Some adolescents may benefit from the use of additional assessment measures and observations that explore differences in social understanding and information processing.

Girls

Research has shown that autistic girls may present differently than autistic boys. For example, the restricted and repetitive patterns of behaviour observed in autistic girls may be less immediately obvious and more similar to the interests of same-aged peers, although differing in intensity. Autistic girls may use compensatory behaviours, such as staying in close proximity to peers and weaving in and out of social groups and activities, which can mask their social challenges (Dean et al., 2017). Caution is advised in interpreting the findings of standardised assessment measures as they may not have been adequately normed for girls.

Despite differences in the presentation of autistic girls, it is still necessary for them to meet all diagnostic criteria. Careful attention to developmental history and trajectory is important in considering diagnosis.

Gender variance

Research shows that a higher proportion of the autistic population identify outside hetero-normative categories in terms of gender and sexual orientation (George & Stokes, 2018; Gilmour et al., 2012). It is important that psychologists are competent in probing the experience and impact of gender identity when integrating information to inform clinical formulation.

Intellectual disability

Diagnostic criteria mandate that autism should not be diagnosed if observed difficulties are better explained by intellectual disability (ID) or global developmental delay (GDD). Children with ID show difficulties or delays in the area of social communication in comparison to age-related peers, for example, difficulties in complex social understanding or in accurately perceiving and interpreting social cues. These expected social difficulties increase with level of severity of ID. In order to diagnose autism, there must be a discrepancy between the individual's observed social communication skills and the expected skills for their level of ID.



Autism assessment of children with ID is complex and challenging, particularly for children with severe to profound ID, where there are often co-occurring medical conditions, sensory impairments, or physical disability. Standardised diagnostic measures have not been validated for these groups and their use is often not appropriate. Children with severe to profound ID are often excluded from research studies.

For children with mild to moderate ID, it is helpful to focus on differences in basic social communication skills that typically emerge in early development, such as eye contact, non-verbal communication skills, shared enjoyment, and simple reciprocal interactions. For older individuals, consideration of the developmental trajectory may be particularly useful. There is very little empirical data about how best to identify autism in children with severe to profound ID, even though this group is overrepresented in relation to the many genetic conditions associated with autism. A team approach to diagnosis is most helpful with experienced clinical judgement playing a key role. Psychologists will require significant consultation/supervision if they are not familiar with working with this population. A more detailed overview of the clinical considerations in differentiating autism and ID may be found in Thurm et al. (2019).

Cultural and linguistic factors

Autism research is heavily skewed toward western high-income countries, where less than a fifth of the global population lives. Within high income countries, ethnic minority groups tend to be underrepresented in autism research populations. As a result, our knowledge of autism is culturally biased and diagnostic instruments lack cross-cultural validity. Research also suggests that children from culturally and linguistically diverse backgrounds are more likely to be misdiagnosed or diagnosed with autism at a later age (Johnson & Myers, 2007; Randall et al., 2018).

It is the psychologist's responsibility to ensure that they have sufficient understanding of the particular cultural context for the child and family to be able to carry out a valid assessment, communicate the assessment findings in a way that is meaningful to the family, and

understand the support needs of the family. Linguistic understanding is necessary but not sufficient to facilitate cultural understanding. Interpreters may be used when needed, but the psychologist should remain mindful of the limitations of working through an interpreter, particularly when attempting to directly assess the social and emotional reciprocity of the child or young person.

Norms and expectations differ across ethnic communities regarding the development of language, social skills, imaginative play, and use of eye contact. Assessment tools and diagnostic instruments may need to be adapted by the psychologist depending on the ethnic group of the child being assessed, informed by awareness of the cultural norms of the child's ethnic group.

Telehealth

At the time of writing, the area of telehealth is an emerging area of research, particularly in the areas of autism diagnosis and intellectual disability assessments. The evidence base is currently limited, and many of the available studies rely on small sample sizes. Telehealth-based assessment components should attempt to elicit and evaluate the same quality of information that would be sought in an "in person" assessment. The decision on whether or not to use telehealth as part of an autism assessment should be guided by clinical considerations and take into account factors such as family capacity and preferences, cultural and linguistic factors, and the establishment of therapeutic relationship and rapport. Telehealth assessment components should currently be used with caution, bearing in mind the most recent evidence base for and against their use with particular populations.



CONCLUSION

The story of autism has evolved rapidly over the past decade, in part driven by changes in presentations and the needs, insights, and aspirations of autistic people and their families. It is hoped that these guidelines support psychologists to provide high quality, values-based, and evidence-informed autism assessments.



DEFINITIONS

Developmentally appropriate - describes an approach to assessment that respects both the age and the individual needs of each child. To be developmentally appropriate, practices must be culturally, linguistically, and ability appropriate for each child.

Efficacy - of screening measures refers to the ability to produce a desired or intended result.

Informed consent - is agreement to participate in the assessment process, having been provided with important information about the assessment, including possible outcomes, an estimate of the duration of the assessment, who will be contacted in connection with the assessment, and what information will be shared. In order for consent to be informed, the parent/guardian and/or young person must first achieve a clear understanding of the relevant facts, risks and benefits, and available alternatives.

Neurodiversity - describes the natural diversity of all minds, similarly to how biodiversity describes the wide variety of plant and animal life. Neurodiversity acknowledges the variety in how minds process information and interact with the world.

Protective factors - are attributes, characteristics and activities of individuals, families, and communities that are associated with people coping effectively with stressful events and with the mitigation of risk factors.

Telehealth - refers to the provision of healthcare remotely by means of telecommunications technology, (e.g., phone calls, video calls, mobile applications).

Standardised measures - are measures designed in such a way that the questions, conditions for administering, scoring procedures, and interpretations are consistent.



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