Assessment, Intervention, and Crisis Response in Neurodiversity-Affirming Care

Assessment Tools & Intake Processes • Interventions, Crisis Prevention & Collaboration

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Learning Objectives

By the end of this session, participants will be able to:

Apply affirming assessment principles

Use a collaborative, strengths-recognizing framework to structure intake and diagnostic assessment for neurodivergent patients.

Design accessible intake processes

Reduce sensory and executive-functioning barriers so patients and families can engage fully from first contact.

Identify crisis prevention strategies

Recognize antecedents and early warning signs, and apply proactive, trauma-informed de-escalation approaches.

Strengthen caregiver collaboration

Build communication practices that partner with caregivers and support interdependence, not just compliance.

Today's Roadmap

90 minutes across two connected sessions

9:00 – 9:45 AM · 0.75 CH

Assessment Tools & Intake Processes

- Why deficit-focused assessment falls short
- The CARES collaborative-assessment framework
- Building an accessible intake, sensory-friendly space & materials
- Masking, lifespan intake (incl. adolescents) & diagnostic accuracy
- Screening tools, communication passports & local advocate partnerships

9:45 – 10:30 AM · 0.75 CH

Interventions, Crisis Prevention & Collaboration

- De-escalation before restraint, and vitals/safety monitoring
- Care team roles during a crisis
- The algorithm for irritability/aggression
- Recognizing behavior across ED, inpatient & dental settings
- Supporting families: collaboration, resources, and closing the loop

Why Affirming Assessment Matters

Most psychological and diagnostic assessments remain largely deficit-focused . They are built to answer "what is wrong, and how do we fix it?"

O'Neil Woods et al. (2005)

A shift in the driving question

Deficit-focused

"What's wrong, and how do we make them more typical?"

Affirming & collaborative

"What are this person's strengths, and how do we meet their goals?"

The CARES Framework for Collaborative Assessment

Five principles for combining neurodiversity-affirming care with collaborative assessment

C

Collaborative Understanding

Co-develop assessment questions with the client/family.

A

Accessibility

Offer multiple ways to communicate and a sensory-friendly space.

R

Recognizing Intersectionality

Consider how identity factors shape each person's experience.

E

Empowerment

Name systemic ableism and help clients build a self-advocating identity.

S

Strengths Recognition

Identify strengths and interests as tools, not just challenges to fix.

O'Neil Woods et al. (2005)

Building an Accessible Intake Process

Before & during first contact

- Explain what to expect before the visit
- Offer a sensory-friendly space
- Reduce paperwork/EF burden; send reminders
- Co-create the assessment questions
- Offer multiple response formats
- Accommodate remote or flexible scheduling

Reframe the intake question

Instead of "what's wrong?" ask:

"What are my strengths?"

"What accommodations should I ask for?"

"Why does this keep coming up?"

O'Neil Woods et al. (2025)

Setting Up the Space: Sensory-Friendly Materials

Physical tools that make the intake room itself part of the accommodation

What to have on hand

- Weighted lap pad or blanket for deep-pressure input
- Fidget tools and textured objects
- Noise-canceling headphones or earplugs
- Visual supports: picture schedule, first-then board, visual timer
- Adjustable lighting; option to dim or avoid fluorescent flicker
- A designated quiet, low-traffic space to retreat to

Norris et al. (2024)

Already modeled elsewhere

Rady Children's Health and Yale New Haven Hospital both stock ready-to-use sensory tool kits by department . This doesn't have to be built from scratch.

A kit can be simple: one bin, reviewed and restocked regularly.

Choosing Tools: Diagnostic Accuracy + Strengths

Gold-standard diagnostic tools

ADOS-2 and similar tools are valuable but require ongoing, neurodevelopmentally informed training to apply in a person-centered way.

Curnow et al. (2023)

Strengths-oriented measures

Pair diagnostic tools with strengths inventories and adaptive-behavior measures so reports describe the whole person.

O'Neil Woods et al. (2025)

Multi-informant, co-interpreted results

Gather data from multiple chosen sources, then interpret findings together with the client.

O'Neil Woods et al. (2025)

Masking and Diagnostic Accuracy

Three ways autistic people camouflage

Compensation

Alternative strategies to work around social/communication differences.

Masking

Actively suppressing visible autistic traits.

Assimilation

Effortfully trying to fit in with peers.

Alaghband-rad et al. (2023)

What this means for assessment

- Don't rule out autism based on eye contact alone
- Observe extended, naturalistic interactions
- Ask what “holding it together” costs after the visit
- Expect camouflaging to differ by gender/culture

Intake Across the Lifespan

EARLY CHILDHOOD

- Developmental history from caregivers/school
- Screening tools + play-based observation
- Caregiver describes triggers & comfort items
- Family often already suspects a diagnosis

ADOLESCENT

- Include the adolescent directly, not just caregiver-report
- Screen for anxiety/depression — onset risk rises sharply
- Ask about puberty, identity, and masking's growing toll
- Start transition-to-adulthood conversations early

ADULT / LATE-DIAGNOSED

- Self-report, often alongside masking effects
- Screen for co-occurring anxiety/depression/burnout
- Ask about work, relationships, masking's toll
- Often self-referred after recognizing traits in family

Curnow et al. (2023); Rock & Becker (2024); O'Neil Woods et al. (2025)

What's Available to Nurses & Entry Providers

You don't need a specialist in the room to screen

Brief tools you can use at the point of care

M-CHAT-R/F

Ages 16–30 mo · ~5 min checklist + follow-up; positive then refer

CSBS Infant-Toddler Checklist

Up to 24 mo · 1-page communication/play screen

ASQ (Ages & Stages)

General developmental screen, 5 domains

Pediatric Symptom Checklist (PSC)

School-age · behavioral/emotional screen

CDC (2025); Zheng et al. (2023)

Why this is available and helpful

- Entry providers see the patient first, often months before a specialist visit
- Tools are built for non-specialists to score reliably in minutes
- A positive screen starts the referral clock immediately

Free Toolkits & Referral Pathways

AAP ASD Screening Toolkit

A free, curated list of validated screening tools, from the American Academy of Pediatrics.

publications.aap.org/toolkits

CDC "Learn the Signs."

Free milestone checklists and provider guidance on screening and referral, in multiple languages.

cdc.gov/autism/hcp

Early Intervention Referral

For any child under 3 with a positive screen, refer directly — in parallel with, not after, diagnosis.

No diagnosis required to start

Key principle: *Don't wait for a definitive diagnosis to refer. A positive screen is enough to start early intervention or a specialist workup in parallel.*

Communication & Environment Adaptations at Intake

Four practical categories of adaptation, co-developed with autistic adults

Adapt the environment

Ask about sensory needs; adjust sound and lighting; reduce or offer alternatives to waiting-room time.

Make disclosure easy

Give a low-pressure way to share an autism diagnosis or traits without needing to justify or explain it.

Adapt direct communication

Use concrete, literal language; allow processing time; ask one question at a time.

Modify written materials

Offer visual schedules, plain-language handouts, and written summaries of verbal instructions.

Norris et al. (2024)

Building a One-Page Communication Passport

A brief, patient-held summary that travels across visits and providers

What it should capture

- Communication style & any AAC device or method used
- Sensory sensitivities and what helps (or makes things worse)
- How this person expresses pain or distress
- Known triggers and effective calming strategies
- Comfort items, interests, and what to talk about to build rapport

NHS Leeds Autism Health Passport (2023)

Why it helps

No intake form captures what a family already knows. A passport means the patient doesn't have to re-explain their needs at every single visit, to every new provider.

Partnering With Local Autism Advocates at Intake

Bring in an ally early, not just as a referral after the visit is over

Who to contact

Autism Action Partnership (Omaha)

Can connect a trained peer or self-advocate to support a family through a visit · 402-763-8830

Autism Society of Nebraska / Omaha Support Network

Peer-to-peer family support; can pair a parent mentor before intake · 800-580-9279

Disability Rights Nebraska

The state's federally designated Protection & Advocacy agency — consult when a family raises a rights or safety concern

Nebraska ASD Network

Training and consultation for providers on evidence-based, affirming practice

Why bring them in at intake

- A local advocate can flag needs your intake form might miss
- Families don't have to explain everything alone, from the first visit
- Ongoing relationships with these agencies build trust over time — not just one-off referrals

SESSION 2

Interventions, Crisis Prevention, & Collaboration

A Quick Note on ABA

For context: this session's strategies are grounded in current, affirming behavior-analytic practice

Autistic self-advocates have raised real concerns about older, compliance-heavy ABA models. Today's behavior-analytic practice has moved to directly answer them:

- Goals are set around the person's own values and quality of life — not conformity to neurotypical norms.
- Assent-based, trauma-informed practice – assent withdrawal is read as communication, not defiance.
- Behavior is understood in context — stimming as valid self-regulation, not something to eliminate by default.

This isn't a different field applying different rules — it's ABA's own ethics code and evidence base in practice, and it's the foundation for the strategies in the rest of this session.

Mathur et al. (2024); Rajaraman et al. (2022)

Proactive, Antecedent-Based Crisis Prevention

A comprehensive crisis prevention program has four components:

1. Identify triggers early

Gather trigger/warning-sign info from patient, family, and records before a crisis.

2. Adjust the environment

Proactive strategies: preferred items, reduced instructions, sensory accommodations.

3. Train the care team

Front-line staff need role-specific training in verbal de-escalation.

4. Debrief & update the plan

Review what happened and revise the plan, **not optional.**

Bernstein et al. (2022)

A Holistic Algorithm for Irritability & Aggression

Evaluate across five domains before restrictive or pharmacologic options:

Biomedical	Psychiatric	Psychosocial	Environmental	Developmental
Pain, illness, sleep, GI, medication	Co-occurring anxiety/mood	Stressors, relationships	Sensory load, demands	Communication, cognitive level

Clinical takeaway: identify and address the underlying driver of the behavior first. Holistic evaluation across all five factors is recommended before escalating to more restrictive interventions.

Ooi, Banno et al. (2023)

De-escalation Before Restraint

Behavioral intervention comes first. Medical intervention only if appropriate, never a substitute for it

1

Verbal de-escalation & environment

Lower voice, reduce stimulation, adjust lighting/noise, give space and time.

2

Offer choice & sensory tools

Preferred items, sensory supports, a menu of options instead of a single demand.

3

Involve a familiar support

Bring in a caregiver, child life specialist, or behavior specialist the patient trusts.

4

Prescriber-directed medication

A decision for the physician or psychiatry team, not a substitute for the steps above.

5

Physical restraint is a last resort

Time-limited, documented, and followed by a debrief. Not a default response.

Context: autistic children are restrained at more than double the rate of their peers when hospitalized.

Dalton & Doupnik (2024); Calabrese et al. (2024)

Vitals & Safety Monitoring During Escalation

A practical guide for the nursing role in the moment

In the moment

- Prioritize safety over non-urgent vitals. Delay if escalation risk is high
- Warm the pulse ox / cuff first; explain each step before touching
- Offer a choice of arm/site and let the patient/caregiver signal ready
- Keep a preferred item or support person present during the exam
- Document what worked (or didn't) so the next visit goes smoother

Why it matters

A rushed vital sign check can itself become the trigger for escalation. Slowing down at intake often saves time overall.

Who Does What: Care Team Roles During a Crisis

Nurse	Behavior Specialist	Physician / Psychiatry	Child Life Specialist	Security / Safety Officer
Vitals & safety, environment, first-line de-escalation	Proactive strategies, behavior plan, coaching the team	Medical rule-out, PRN medication orders	Distraction, coping support, procedural preparation	Physical intervention only when necessary, least invasive

Clear roles prevent both gaps and collisions, everyone should know their role before the crisis starts.

Call et al. (2022)

How Significant Challenging Behavior Presents

Read it as communication first

Aggression or self-injury

Often a response to pain, fear, or an unmet communication need, not defiance.

Elopement / fight-flight

Bolting when demands or sensory input exceed what can be tolerated.

Shutdown or refusal

Going still, silent, or non-responsive under stress.

Repetitive vocalizations/stimming

Increased self-regulation under stress — a coping strategy to interpret.

The question is never just "what is this behavior?" — it's "what is this person trying to tell us, right now?"

Addressing It Across Medical Settings

Emergency Department

Noise, lights, and long waits drive sensory overload and escalation.

- Low-stimulus space; dim lights
- Fast-track / provider-in-triage
- Bring in caregiver-known triggers
- Nursing partners with OT on sensory-friendly triage

Hamad et al. (2026)

Inpatient / Hospital Ward

Disrupted routines and rotating staff are common triggers; agitation can mask a medical cause.

- Preserve preadmission routines
- Multidisciplinary trigger plan on entry
- Rule out medical causes first
- OT/PT join rounds for sensory & mobility needs

Burke et al. (2024)

Outpatient Clinics

Close contact and required stillness make dental, lab work, and other appointments a common site of distress.

- Desensitization across visits
- Visual schedules, step-by-step narration
- Reserve sedation for when needed
- OT co-treatment builds sensory tolerance over time

Son et al. (2024)

Partnering With Caregivers Across the Care Team

What affirming collaboration looks like

- Involve caregivers as partners in goal-setting
- Share plans in accessible language; revisit after incidents
- Coordinate explicitly across disciplines instead of silos
- Model affirming language caregivers can extend at home

Wagland et al. (2025)

Remember

A neurodiversity-affirming approach treats caregivers and patients as experts on their own lived experience. Our clinical expertise works alongside theirs, not above it.

Supporting Parents Through the Process

Know where to send families before they have to ask

Resources to connect families with

Your facility's Social Work & Care Coordination

Psychosocial support, discharge planning, financial/insurance navigation, and community referrals

PTI Nebraska

Free, statewide parent training & one-to-one support, birth to age 26 · 800-284-8520

Munroe-Meyer Institute (UNMC)

Diagnostic and behavioral services with embedded family support staff

Nebraska Early Development Network

Early intervention referral and services, birth to age 3

Autism Society of Nebraska

Peer support and community connection for families statewide

Why it matters

Parents' own needs and advocacy experience, not just their child's clinical needs, shape how a hospitalization goes. Loop in support proactively; don't wait for a family to ask.

Klinepeter et al. (2024)

Closing the Loop After a Crisis

Autistic patients frequently return to acute care without adequate follow-up

Before the patient leaves

- Schedule the follow-up appointment before discharge
- Share the updated behavior/crisis plan with outpatient team
- Document specific triggers and what worked
- Offer a warm hand-off to the outpatient behavior therapist

Jeglum et al. (2024)

Why it matters

Children and adolescents with ASD often return to the ED for challenging behavior. A signal that follow-up and referral gaps exist, not that the crisis was random.

Key Takeaways

Collaborate from intake onward

Build assessment questions, accommodations, and reports with patients and families.

Meet critiques with evidence

Assent-based, trauma-informed ABA already answers the concerns families raise.

Prevent, don't just react

Antecedent-based, trigger-informed planning outperforms reactive crisis response.

Treat caregivers as care-team members

Sustained collaboration, not one-time hand-offs, drives better outcomes.

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