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Improving quality of life for children with autism through intervention, education and research.
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Autism Diagnostic Criteria

Autism spectrum disorders (ASD) refer to several pervasive developmental disorders related to a continuum of symptoms related to autism. ASD encompasses Autism, Asperger’s Disorder, and Pervasive Developmental Disorder – Not Otherwise Specified or Atypical Autism.

Autism is the model form of ASD that is characterized by the presence of impaired social interaction and communication. In addition to these impairments, there is a markedly restricted repertoire of activity and interests. The severity and manifestation of the disorder varies greatly from child to child. Autism is also referred to as “early infantile autism,” “childhood autism” and “Kanner’s autism.”

Early Warning Signs
Below are early indicators of autism that may be useful for parents to identify early warning signs.

- Child may appear deaf.
- Child may appear “very good” or “very fussy.”
- Child may exhibit self-stimulatory behavior.
- Child may be a “selective” eater.
- Child may not exhibit anticipatory responses.
- Child may avoid eye contact.
- Child may no appear aware of what is happening.
- Child may desire “sameness.”
- Child may not communicate at age level.
- Child may repeat words or phrases over and over without understanding what is being said.
- Child may appear to be a perfectionist.
- Child may have a wide range of skills inconsistent with developmental levels.
- Child may exhibit high or low tolerance of pain.
- Child may no imitate others.
- Child may not generalize acquired information.
- Child may exhibit hypo or hyper sensory sensitivities.
- Child may have difficulty interacting with other children.
- Child may form extreme attachments to objects.

Diagnostic Criteria
Below is a brief list of the diagnostic criteria used by psychologists to diagnose autism.

A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):

(1). Qualitative impairment in social interaction, as manifested by at least two other following:

1 Information from the Commonwealth Autism Service and can be found at www.autismva.org
(a). marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
(b). failure to develop peer relationships appropriate to developmental level
(c). a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
(d). lack of social or emotional reciprocity

(2). Qualitative impairments in communication as manifested by at least one of the following:

(a). delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture of mime)
(b). in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
(c). stereotyped and repetitive use of language or idiosyncratic language
(d). lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

(3). Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

(a). encompassing preoccupation with one or more stereotyped and restricted patterns of interests that is abnormal either in intensity or focus
(b). apparently inflexible adherence to specific, nonfunctional routines, or rituals
(c). stereotyped and repetitive motor mannerisms (e.g., hand or finder, flapping, or twisting, or complex whole-body movements)
(d). persistent preoccupation with parts of objects

B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play

E  The disturbance is not better accounted for by Rett’s Disorder or Childhood Disintegrative Disorder.
Asperger’s Disorder Diagnostic Criteria

Asperger’s disorder is characterized by severe and sustained impairment in social interaction and restricted, repetitive patterns of behavior, interests and activities. Unlike autism, there are no significant delays in language acquisition, but there may be subtle impairments in social communication (e.g., turn taking in conversation). In addition, there are no significant delays in cognitive development (e.g., curiosity about the environment, adaptive behaviors and acquisition of age-appropriate learning skills) during the first three years of life.

Below is a brief list of the diagnostic criteria used by psychologists to diagnose Asperger’s disorder.

A. Qualitative impairment in social interaction, as manifested by at least two of the following:

(1). Markedly impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
(2). Failure to develop peer relationships appropriate to developmental level
(3). A lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest to other people)
(4). Lack of social or emotional reciprocity

B. Restricted repetitive and stereotyped patterns of behavior, interests and activities as manifested by at least one of the following:

(1). Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
(2).Apparently inflexible adherence to specific, nonfunctional routines or rituals
(3). Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping, or twisting or complex whole-body movements)
(4). Persistent preoccupation with parts of objects

E. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning

D. There is no clinically significant general delay in language (e.g., single words used by age 2 years, communicative phrases used by age 3 years)

E. There is no clinically significant delay in cognitive development or in the development of age appropriate self help skills, adaptive behavior (other than in social interaction), and curiosity about the environment in childhood.

F. Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia.

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How is ASD diagnosed?4

For the first time, standard guidelines have been developed to help identify autism in children before the age of 24 months. In the past, diagnosis of autism was often not made until late preschool-age or later. The new guidelines can help identify child with autism early, which means earlier, more effective treatment for the disorder.

The standard guidelines were developed with assistance from 11 different organizations and were published in Neurology, a journal of the American Academy of Neurology. According to the guidelines, all children before the age of 24 months should routinely be screened for autism and other developmental delays at their well-child check-ups. Children that show developmental delays and other behavior disorders should be further tested for autism. According to the guidelines, less than 30 percent of children undergo age-appropriate screening at their well-child check-ups. By screening children early for autism, those diagnosed with the disorder can be treated immediately and intensively.

The first level of screening should be performed by the child’s physician at the well-child check-up during the first two years of life. The physician should look for signs of developmental deficit. This should include a screening measure, such as the Modified Checklist for Autism in Toddlers (MCHAT), though others might also be used. The MCHAT can be used to screen children as young as 18 months. Although this screener cannot diagnose an ASD, it can indicate when further assessment is appropriate. The following is a list of developmental deficits that could indicate autism:

- No babbling, pointing, or gesturing by age 12 months
- No single words spoken by age 18 months
- No two-word spontaneous (non-echolalic, or not merely repeating the words of others) expressions by age 24 months
- Loss of any language or social skills at any age

The second level should be performed if there are warning signs of a developmental delay. This is a more in-depth evaluation that can differentiate autism from other developmental disorders and is typically performed by psychologists and/or neurologists. This evaluation will assess a wide range of areas, such as the child’s medical history (including prenatal development), psychological assessments, neurological evaluations, and speech/language evaluations. The Autism Diagnostic Interview-Revised (ADI-R) and the Autism Diagnostic Observation Schedule (ADOS) are current state-of-the-art assessments that are recommended. The ADI-R is a structured interview of the parent, while the ADOS is a structured observation of the child. Both assess children as young as 18 months on three domains: quality of social interaction, communicative skills, and repetitive, restricted and stereotyped behaviors/interests.

At the Virginia Tech Autism Clinic, we assess the child on three major domains: medical history and development, behavioral evaluations and observations, and cognitive evaluations. Depending on the particular child, other evaluations may be used to assess other concerns, such as anxiety. In addition to our evaluation, we recommend an evaluation from a physician to evaluate medical conditions that may be related to the current symptoms, and from a speech-language pathologist to assess the extent of difficulty in language/communication.

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4 Information adapted from Commonwealth Autism Service and can be found at [www.autismva.org](http://www.autismva.org).
What treatments are available?

Parents of individuals diagnosed with autism spectrum disorders are frequently overwhelmed when confronted with the many treatments/educational approaches suggested for working with their children. The following is a list and brief explanation of some of the widely used techniques. This list is NOT exhaustive. Additionally, some of the techniques are comprehensive programs, while others are designed to target a specific area of difficulty. In addition, some of these intervention techniques are commonly used together to create the best intervention for the particular individual.

Applied Behavior Analysis

Applied Behavior Analysis (ABA) is a scientifically-based treatment and teaching approach consisting of several different specific programs which use the antecedent-behavior-consequence model as a basis for teaching. All actions are thought of as behavior, and each action is analyzed to determine what precedes it, how it occurs, and what follows the behavior in order to decrease inappropriate behaviors and increase appropriate behaviors.

Although often collectively referred to as ABA, there are some differences between many of the specific methodologies in ABA.

Local Resources


Discrete Trial Teaching

Discrete Trial Teaching (DTT) is a teaching strategy widely utilized in ABA interventions. This strategy allows individuals to master complex tasks by first learning and mastering subcomponents of the task. This strategy has been shown to be effective in teaching communication skills, gross and fine motor skills, social skills and daily living skills.

DTT has been shown to be a highly effective intervention for individuals with autism spectrum disorders. However, for the intervention to be most successful, it should be done for 30-40 hours a week in the child’s home, starting as early as possible, typically by 3 years of age.

Please note that because of the limitations of DTT, many current ABA organizations, such as the Center for Autism and Related Disorders (CARD) use other methods of teaching as individuals progress to learning more complex social skills. Therefore, it is important to research the specific teaching methods and their effectiveness that individual ABA organizations use.

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5 Information adapted from Autism Society of America and can be found at [www.autism-society.org](http://www.autism-society.org).
Resources:

Center for Autism and Related Disorders: [http://www.centerforautism.com](http://www.centerforautism.com)
  This website offers more information about ABA interventions, including how to evaluate ABA programs.

*Behavioral Intervention for Young Children With Autism: A Manual for Parents and Professionals* By: Catherine Maurice, Gina Green, Stephen C. Luce
  This book gives a detailed overview of how to set-up an ABA program from funding issues, to choosing professionals and therapists.

*A Work in Progress* by Ron Leaf and John McEachin
  This book provides behavior management strategies and a curriculum for intensive behavioral treatment of autism.

Pivotal Response Training
Also based on Applied Behavior Analysis (ABA) theory, PRT focuses on an instructional method which teaches social communication that is functional and spontaneous. This form of ABA offers a structured way to interact during the individual’s daily routine in a comfortable, more naturalistic manner. PRT teaches “pivotal” behaviors shown to be central to wide areas of functioning, including motivation, responsivity to multiple cues, self-management, and independent responding. PRT techniques are often taught to parents to allow the child to have the greatest exposure in their every-day lives. Additionally, this training is designed to enable the individual to be more involved in inclusive environments and thus lends itself to use in school settings. PRT has been shown to be effective.

Local Resources:

Virginia Tech Autism Clinic: [http://www.psyc.vt.edu/centers/psc/clinics/autism](http://www.psyc.vt.edu/centers/psc/clinics/autism)
  Our clinic offers a 25 hour parent training in PRT, as well as social skills and emotion management groups. Please call for availability (540-231-2053).

Resources:

  This website offers many resources on PRT, including various manuals for purchase.

*Pivotal Response Treatments for Autism*
By: Robert L. Koegal and Lynn Kern Koegal

*Teaching Children With Autism: Strategies for Initiating Positive Interactions*
By: Koegel & Koegel

*Overcoming Autism: Finding the Answers, Strategies, and Hope That Can Transform a Child’s Life*
By: Koegel & LaZebnik
Other Treatments

**Floor Time**
This therapeutic approach seeks to improve developmental skills through analysis and intervention in six areas of functioning, centered on attentional skills, social interactive skills and communicative skills. More advanced skills, such teaching the child to create mental representation or emotional symbols through engagement in pretend play and emotional intention, are also addressed. Dr. Greenspan is the most well-known promoter of this intervention strategy.

**TEACCH**
The strategies of this program are visually based and relate individually on the basis of a detailed assessment of needs and abilities, trying to identify potential for acquisitions rather than focusing on deficits. A basis for this intervention is the concept of “structured learning.” This technique is based on the assumption that individuals with autism learn and integrate information differently than other children. It assumes that many non-compliant behaviors of children with autism are the result of a difficulty understanding what is expected.

Structured teaching places heavy reliance upon teaching through visual modes due to the difficulties that children with autism have with processing verbal information. Visual structure is provided at a variety of levels. Classrooms can be organized to add visual structure, daily visual and/or written schedules can be used and visual instructions and organization can be used to signal the beginning and the end of activities.

**Picture Exchange Communication System (PECS)**
This therapeutic approach is a communication training system developed within the Delaware Autistic Program by Dr. Andy Bondy. PECS is used with students from the ages 2 through 21 years, although it can be adapted to meet the needs of older individuals. Its basis is applied behavior analysis and discrete trial training.

Individuals using PECS are required to give a picture of a preferred item to a communicative partner in exchange for the item. Requesting of items is the first skill targeted in the PECS teaching method. Within this teaching phase, the preferred items are presented as reinforcement of the response. This training is designed to be used in social environments. The only prerequisite to the beginning of this training method is the ability to identify those items or activities that are preferred by the individual. Once the child learns how to use the pictures to communicate their wants and needs, the child is then encouraged to verbalize the request.

**Dietary Interventions/Megavitamins**
Several researchers have hypothesized that diet, food allergies or intolerance, or yeast may contribute to or even cause autistic symptoms. Interventions in support of this hypothesis include casein and gluten free diets, antifungal medications, herbal treatments and mega-doses of vitamin B6 and Magnesium. Although anecdotal evidence (parent reports) seem
promising, at this time, no well controlled studies have supported or refuted this theory.

<table>
<thead>
<tr>
<th>Local Resource:</th>
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<tbody>
<tr>
<td>Dr. Elizabeth Mumper, Pediatrician</td>
</tr>
<tr>
<td>2015 Tate Springs Road</td>
</tr>
<tr>
<td>Lynchburg, Virginia</td>
</tr>
<tr>
<td>Phone: 434-528-9075</td>
</tr>
</tbody>
</table>

**Speech Therapy**
Many individuals with ASD have difficulties with communication. In general, speech therapy can help an individuals improve both communication and behavior because it can target various communication deficits. In addition to speech therapy, some individuals with ASD can learn to use communicative devices to help meet their needs. Higher functioning individuals can also benefit from this type of therapy because it can be used to address language pragmatics, or the give and take of conversation for social purposes.

**Occupational Therapy**
Many individuals with ASD also have difficulties with fine and gross motor skills. In general, Occupational therapy can help individuals improve in these areas by specifically targeting the individual’s fine and gross motor deficits.
How do I Evaluate Treatments?

One of the major questions parents have in regards to treatment is to know how to assess whether or not a treatment is right for their child. To help parents, we have compiled a list of questions to ask service providers. These questions are designed to help parents ensure that their child is obtaining services from a service provider who has expertise treating individuals with autism and can develop a quality individualized treatment plan.

Service Providers Qualifications

- What qualifications (e.g., BCBA, Ph.D., M.A., etc.) does the service provider have?
- How long has the service provider been providing these types of services?
- How many individuals with autism has this provider treated?
- What are the outcomes of their clients?
- What will their exact role in your child’s treatment be (e.g., overseeing program, conducting therapy, etc)?
- How many hours a week/month will the service provider see your child?
- Can he/she provide three other referrals? Can you contact them?
- If there is an emergency, can you contact them, and how?

Program Quality

General
- Is the program based on current research findings?
- Does the program keep up with current research findings?
- Are the hours of therapy recommended consistent with research findings?
  - Note: For most treatments, 25-40 hours a week has been shown to be most effective.
- Is consistency ensured (e.g., frequent consultation with family, teachers, and other people who may interact with the child on a frequent basis)?
- Is the program adequate for non-verbal children?

Individualized Treatment
- Is the program individualized to your child’s progress or is a “cookbook” approach used?
- How does the program measure progress?
- How often is your child’s progress reviewed?
- What happens if your child is not progressing on a particular skill?
- Is there emphasis put on generalizing skills?
- Can the program be specialized to my child’s strengths and interests?
- Can the program target reduction of negative behaviors, such as hitting, biting, etc?
Developing an IEP

Learning about an Individual Education Plan (IEP)

Meetings should always start on a positive note by discussing your child’s strengths. This is known as “current level of functioning” or “present level of educational performance.” In order for a child to be appropriately served by Special Education Services, each child must be viewed as a “whole child,” with gifts and talents and abilities. Focus on positive, not simply the deficits. The way in which a child learns should also be addressed. For example, some children focus on visual learning; while other children, learn better by “doing” or experiencing. Others may need different supports to enhance their learning style. Every child is different. No two children in a class will (or should) have the same Educational Plan. A child’s strengths should be a part of any IEP and these strengths should be drawn upon when developing goals and objectives.

You may want to:

• At least a week or two before your IEP meeting, start observing your child.
• Keep a journal or list of things that you notice that she/he CAN do.
• Also think about the things that you would like your child to be able to do that are developmentally appropriate.
• List your concerns about your child’s future.
• Think about what your child needs.

The school system is mandated by the federal government by the Individuals with Disabilities Education Act (IDEA) to provide for your child’s needs. They are also required to give your child a Free and Appropriate Public Education (FAPE). It is helpful to bring your ideas about what your child needs, in writing, with you to the team meeting.

When thinking of your child’s needs, don’t be limited by what you think may or may not be available at the school. It’s called an IEP because a program must be individualized to each student. The program must “fit” the student.

Common Parts of IEP and IEP meeting

Your Child’s Needs

Needs should be detailed, comprehensive and represent physical abilities, communication abilities, cognitive abilities, social and emotional behavior, developmental and educational growth, self-help skills and other areas specific to your child.

Goals

Goals should be realistic. What is important for your child to learn or to do, from the perspective of the child, the parents and the family? Goals should not be written on the basis of what grade the child is in, what school the child is in or any other factor. Goals should be individualized to the child and have a strong correlation with the needs stated. Goals should be written in plain terms, easily understandable to anyone who reads them. Remember that goals should be activities that the child can accomplish. They should not be isolated behaviors or skills.

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6 Information taken from Commonwealth Autism Service and can be found at www.autismva.org.
Progress Measurement
Short-term objectives are the “baby-steps” a child will use in reaching the goals. Most goals will have more than one short-term objective, and the objectives usually build on one another. Once the child has mastered the first objective, he/she moves on to the next, until the goal has been achieved.

Short-term goals should be measurable and observable! Make sure the IEP states how they will be measured. Below are common ways to test short-term goals:
- Testing
- Daily data collection
- Teacher notes
- Teacher observation
- Parent Observation

Short-term goals need to have timelines that are met. Parents play an important role in meeting with school personnel to monitor the timelines and process. It is just as much the parent’s responsibility to initiate communication with school personnel as it is for the school personnel to keep the parents informed.

Related Services
There is no set formula for the delivery of Related Services; the formula should be individualized to the child’s needs and goals. Related Services are whatever the IEP team (which you as a parent are apart of) decides the child needs to be successful. Related Services need to be relevant to the student and her/his academic day.

Related Services can include:
- Therapy
- Transportation
- Counseling services
- Assistive technology
- Interpreters

Parent Counseling and Training
Parent counseling and training should also be discussed at the IEP meeting. The school is responsible for helping parents to acquire the necessary skills that will allow them to support the implementation of their child’s IEP.

Extended School Year Services
The team should talk about the possible need for extended school year services. This is exactly what the name implies—school extended beyond the regular school year. Please let the school know that you are aware of these services.

Signing the IEP
After the IEP has been written, the parent is asked to sign the forms. If you agree with what has been written, this is wonderful! If you have questions, don’t understand something or don’t agree with something on the IEP, you do not have to sign the form at that time. Schedule another meeting. Ask questions. Try to resolve the issues. You as the parent, have the legal right to object to any IEP that you think is not in the best interest of your child. If there are only a few
minor sticking points, you may want to consider signing the forms and writing down what it is that you don’t agree with next to your signature. Plan on working things out at a later time. Schedule another meeting. This way your child can at least begin to receive the services he/she needs with which you agree. If you come to a total impasse, then you have the right to ask for mediation.

**Mediation**
Mediation is provided, free of charge, by the State Board of Education. They have hired impartial individuals who have gone through special training in order to help parents and school systems resolve disputed issues. The idea is to bring in a third party who may be able to help the two parties involved find some form of middle ground that they can agree upon. The hope is to have everyone agree to the new IEP in order to keep from going to Due Process.

**Due Process**
Due Process is what you request when you feel that mediation has failed and you believe you have a situation with legal merit. If you feel you need to go this route, you may want to contact the Parent Education and Advocacy Training Center at 1-800—869-6782 for more information. Or visit the Commonwealth Autism Service website at [www.autismva.org](http://www.autismva.org) for additional resources.

**Placement**
The placement of your child should not be determined until after the IEP process has been written. The placement of where your child is to be educated is based on the Least Restrictive Environment. Can the child function in a regular education classroom with added supports? For example, an aide or being close to natural light of the window or having other things in the classroom moved around to assist with the child’s needs. If the child would have a difficult time in this environment, look at other classrooms that might have smaller group settings, more structure, or other things that would be able to assist the child in achieving her/his IEP goals. Always starts with the least restrictive environment and work toward the more restrictive settings until you find the proper match for your child.

**Resources for learning about the IEP process**
The Virginia Department of Education, Div. of Special Education—[www.pen.k12.va.us/VDOE/ness/](http://www.pen.k12.va.us/VDOE/ness/)

Judy Hudgins, Virginia Department of Education, Parent Specialist
Phone: 804-371-7421
E-mail: [Judy.Hudgins@doe.virginia.gov](mailto:Judy.Hudgins@doe.virginia.gov)

Pete Wright, Special Education Lawyer
Website: [www.wrigtslaw.com](http://www.wrigtslaw.com)

Parent Education and Advocacy Training Center, Virginia
Trains parents of children with disabilities on how to negotiate the process of obtaining their rights
Website: [www.peatc.org](http://www.peatc.org)

Special Education Law
A multi-disciplinary internet resource for parents of special needs children, as well as attorneys, special education administrators, teachers, psychologists and others with a need for information relating to special education law. Website: www.specialedlaw.net

Books

Creating a “Win-Win IEP” for Students with Autism, second edition, Beth Fouse, Ph.D., 1999.

National and State-wide Resources

National Resources

Autism Speaks
Autism Speaks is a national autism organization that seeks to promote autism awareness, advocacy and research.
Website: [http://www.autismspeaks.org/](http://www.autismspeaks.org/)

National Autism Center
The National Autism Center is a new nonprofit organization dedicated to supporting effective, evidence-based treatment approaches and providing direction to families, practitioners, organizations, policy-makers and funders. The center is bringing nationally renowned experts together to establish national standards, model best practices, and conduct applied research, serving as a vital source of information, training and services.
Website: [www.nationalautsimcenter.org](http://www.nationalautsimcenter.org)
E-mail: info@nationalautismcenter.org
Phone: 1-877-313-3833

Virginia Resources

Commonwealth Autism Service
Provides information on resources and support groups in your area
Website: [www.autismva.org](http://www.autismva.org)
Phone: 1-800-649-8481 or 804-355-0300

Department of Medical Assistance Services (DMAS)
Oversees the Virginia Medicaid Waiver System, including Developmental Disabilities (DD) and the Mental Retardation (MR) Waiver Services
600 East Broad Street, Richmond, VA 23219
Website: [www.dmas.virginia.gov](http://www.dmas.virginia.gov)
Phone: 804-786-4231

Infant and Toddler Connection
A system of services and supports designed to promote the greatest possible developmental outcomes for Virginia’s infants and toddlers (birth to age 3) with developmental delays or disabilities. The system has been established in accordance with the Individuals with Disabilities Education Act (IDEA), Part C-Early Intervention.
Department of Mental Health, Mental Retardation and Substance Abuse
Early Intervention Program, Managed through your local Community Services Board
Website: [www.infantva.org](http://www.infantva.org)
Phone: 804-786-3710
Contact: Ms. Shirley Ricks, Manager of MR Children and Family Services, Email: sricks@co.dmhmrssas.virginia.gov

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Information taken from Commonwealth Autism Service and can be found at [www.autismva.org](http://www.autismva.org).
Parent Educational Advocacy Training Center (PEATC)
Parenting a child with a disability means you may need to be an expert at navigating a complex maze of educational, health care, and social services for your child. Being your child’s advocate in these areas can be a challenge. This organization provides information to help you navigate these complex systems.
6320 Augusta Drive, Suite 1200, Springfield, VA 22150
Phone: 703-923-0010 or 1-800-869-6782
E-mail: partners@peatc.org
Website: www.peatc.org

Roadmap to Services
Although many organizational resources are available throughout Virginia, those included in this resource guide are only intended to be your lead resources and will serve as the first point of reference as you learn more about services within your own community.
Website: www.varoadmap.com

Project Lifesaver
Project lifesaver is an innovative and rapidly growing program aiding the victims and families suffering from Alzheimer’s Disease and related disorders such as Down’s Syndrome and Autism. Project lifesaver uses state-of-the-art technology employing wristband transmitters to locate wandering and lost adults and children.
815 Battlefield Blvd., South Chesapeake, VA 23322
Phone: 757-546-5502
Website: www.projectlifesaver.org
Family Support Groups

Military Support Group
Website: http://groups.yahoo.com/group/NavyFamilieswithSpecialNeeds

STOMP (Specialized Training of Military Parents)
STOMP is a federally funded Parent Training Information Center established to assist military families who have children with special education or health needs.
Website: www.stompproject.org

MUMS, a national Parent-to-Parent Network
A national organization for parents or care providers of a child with any disability, disorder, chromosomal abnormality or health condition. Its main purpose is to provide support to parents in the form of a networking system that matches them with other parents who children have the same or similar condition. Parents can exchange valuable medical information, as well as, the names of doctors, clinics, and medical resources or research programs. MUMS also connects parents with support groups dealing with their child’s specific disability or assists them in forming a support group.
Phone: 1-877-336-5333
E-mail: mums@netnet.net

Our Daughters with Autism Network
E-mail networking group
Website: www.gwinnandassociates.org
Contact: Cindy Gwinn, email: Cindygwinn2004@yahoo.com

Parent to Parent (the ARC of Virginia)
Matches a parent just learning of their child’s diagnosis with a volunteer veteran parent of a child with a similar diagnosis. Veteran parents are specifically trained to provide informational and emotional support.
Website: www.arcofva.org
Phone: 1-888-604-2677, ext. 5

ROCK (Raising Our Celiac Kids)
Contact: Kathi Rogers, phone: 804-364-2339, e-mail: RogersKath@aol.com

Talk Autism
Talk Autism is a communication service shared by many organizations who access a common database of resource directories, distance learning library, and special message boards. By sharing a central yet customized communication platform users can find resources here or virtually within our partners’ websites.
Website: www.talkautism.com

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8 Information taken from Commonwealth Autism Service and can be found at www.autismva.org.
New River Valley Resources

**Medical/Diagnostic Resources**

Dr. Circe P. Cooke, Psychiatry  
Carilion New River Valley Outpatient Behavioral Health  
2900 Tyler Road  
Christiansburg, VA 24073  
Phone: (540) 731-7311

Dr. Kathy Kerkering, Pediatric Neurodevelopmental Specialist  
Pediatric Neurodevelopmental Clinic  
1030 S Jefferson St. Suite 201  
Roanoke, VA 24016  
Phone: (540) 224-4520

Dr. Michael Sisk, Neurologist  
Roanoke Neurological Associates  
4431 Starkey Rd SW  
Roanoke, VA 24018  
Phone: (540) 342-0211

Kluge Rehabilitation Center  
University of Virginia  
2270 Ivy Road  
Charlottesville, VA  
434-924-8184

Speech and Language Evaluation  
Radford University Autism Center  
Box 6961  
Radford, VA 24142  
Phone: 540-831-7ASD (7273)  
Website: [http://www.radfordautism.org/ru-benefits](http://www.radfordautism.org/ru-benefits)

Dr. Elizabeth Mumper, Pediatrician  
2015 Tate Springs Road  
Lynchburg, Virginia  
Phone: 434-528-9075  

**Intervention Resources**

Virginia Tech Autism Clinic  
Director: Dr. Angela Scarpa  
3110 Prices Fork Rd  
Blacksburg, VA 24061  
Phone: 540-231-2053
E-mail: autism@vt.edu  
Website: http://www.psyc.vt.edu/centers/psc/clinics/autism/

Blue Ridge Autism Center (BRAC)  
P.O. Box 226  
Blue Ridge, VA 24064  
Phone: (540) 777-1216  
E-mail: brac.1@juno.com  
Website: http://www.blueridgeautismcenter.com/index.html

Early Intervention Services  
Contact: Joan Behl  
Email: JBehl@nrwcs.state.va.us  

**Parent Resources**

Blacksburg Autism Parent Support Group  
Contact: Susan English  
Phone: (540) 449-1809  
Email: englisue@yahoo.com

Montgomery County Parent Resource Center  
Contact: Barbara Greenberg  
Phone: (540) 381-6175  
Email: bgreenberg@mcps.org

Pulaski County Parent Resource Center  
Contact: Jackie Myal  
Phone: (540) 643-0204  
Email: jfmyal@pcva.us

Radford Parent Resource Center  
Phone: (540) 731-3679

Autism Society of America-Greater Roanoke Valley Chapter  
Contact: Shirl Light  
Email: swlight12@juno.com

Friday Night Friends  
Respite care for parents of children with special needs  
Website: http://www.freewebs.com/lbgersuk/

Community Opportunities (Co-Op), Inc.  
Helps individuals set-up and maintain Micro-Boards. Micro-Board assist individuals in living an independent life, yet have a support system in place when they need it.  
P.O. Box 11204, Blacksburg, VA 24062-1204  
Phone: 540-961-7346  
E-mail: MicroboardsNRV@aol.com