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Original Article

Care for People with Autism Spectrum Disorder in Rehabilitation: protocol and therapeutic strategies

Atendimento às Pessoas com Transtorno do Espectro Autista na Reabilitação: protocolo e estratégias terapêuticas

Atención a las Personas con Trastorno del Espectro Autista en la Rehabilitación: protocolo y estrategias terapéuticas

Abstract

Objective: To describe the interdisciplinary care model provided to individuals with Autism Spectrum Disorder (ASD) at the Specialized Rehabilitation Center (SRC), with an emphasis on the care protocols and therapeutic strategies adopted. **Method:** A descriptive study based on a document analysis of the SRC's Care Protocol for Individuals with ASD. Institutional guidelines, inclusion criteria, the structure of individual and group care, family involvement, and coordination with the healthcare network were examined. **Results:** The protocol establishes a structured workflow for assessment and rehabilitation, including early intervention for children at psychological risk, group sessions organized by age group, and ongoing support for families. The interdisciplinary approach allows for comprehensive care, coordinating different specialties to promote the inclusion and functional development of service users. **Conclusion:** The model adopted by SRC contributes to the rehabilitation of individuals with ASD, reinforcing the importance of interdisciplinary care. The standardization of care pathways and coordination with the healthcare network expand the possibilities for social inclusion and the promotion of service users' autonomy.

Descriptors: Autism Spectrum Disorder; Rehabilitation; Patient Care Team; Social Inclusion; Public Health.

Resumo

Objetivo: Descrever o modelo de atendimento interdisciplinar oferecido a pessoas com Transtorno do Espectro Autista (TEA) no Centro Especializado em Reabilitação (CER), enfatizando os protocolos assistenciais e estratégias terapêuticas adotadas. **Método:** Estudo descritivo baseado na análise documental do Protocolo de Atendimento à Pessoa com TEA do CER. Foram examinadas diretrizes institucionais, critérios de inclusão, estrutura dos atendimentos individuais e em grupo, participação da família e articulação com a rede de atenção à saúde. **Resultados:** O protocolo estabelece um fluxo estruturado para avaliação e reabilitação, incluindo intervenção precoce para crianças com risco psíquico, atendimentos em grupo organizados por faixa etária e suporte contínuo às famílias. A abordagem interdisciplinar permite um acompanhamento integral, articulando diferentes especialidades para favorecer a inclusão e o desenvolvimento funcional dos usuários. **Conclusão:** O modelo adotado pelo CER contribui para a reabilitação de pessoas com TEA, reforçando a importância da assistência interdisciplinar. A padronização dos fluxos e a articulação com a rede de atenção ampliam as possibilidades de inclusão social e promoção da autonomia dos usuários.

Descritores: Transtorno do Espectro Autista; Reabilitação; Equipe Interdisciplinar de Saúde; Inclusão Social; Saúde Pública.

Resumen

Objetivos: Describir el modelo de atención interdisciplinaria que se ofrece a las personas con Trastorno del Espectro Autista (TEA) en el Centro Especializado en Rehabilitación (CER), haciendo hincapié en los protocolos de atención y las estrategias terapéuticas adoptadas. **Método:** Estudio cualitativo de campo, realizado con profesionales de la salud de la UCI para Estudio descriptivo basado en el análisis documental del Protocolo de Atención a Personas con TEA del CER. Se examinaron las directrices institucionales, los criterios de inclusión, la estructura de las atenciones individuales y grupales, la participación de la familia y la articulación con la red de atención de salud. **Resultados:** El protocolo establece un flujo estructurado para la evaluación y la rehabilitación, incluyendo la intervención temprana para niños con riesgo psíquico, atenciones grupales organizadas por grupo de edad y apoyo continuo a las familias. El enfoque interdisciplinario permite un seguimiento integral, articulando diferentes especialidades para favorecer la inclusión y el desarrollo funcional de los usuarios. **Conclusión:** El modelo adoptado por el CER contribuye a la rehabilitación de personas con TEA, reforzando la importancia de la asistencia interdisciplinaria. La estandarización de los flujos y la articulación con la red de atención amplían las posibilidades de inclusión social y promoción de la autonomía de los usuarios.

Descritores: Trastorno del Espectro Autista; Rehabilitación; Grupo de Atención al Paciente; Inclusión Social; Salud Pública.

INTRODUCTION

Autism Spectrum Disorder (ASD) is a condition characterized by challenges in communication, social interaction, and the presence of repetitive behavioral patterns⁽¹⁻²⁾. According to estimates from the Autism and Developmental Disabilities Surveillance Network of the Centers for Disease Control and Prevention (CDC), which systematically tracks the prevalence of ASD, approximately one in every 36 children has been identified with the disorder. The data indicate that the global prevalence has more than doubled in 12 years⁽³⁾.

ASD has had a major impact on the lives of affected individuals and their families, with a significant increase in the number of diagnoses in recent years. This increase is related to the expansion of diagnostic criteria, greater awareness, and early diagnosis. A multidisciplinary approach, including behavioral and pharmacological therapies, is fundamental to treatment. However, challenges in early diagnosis and a lack of adequate information remain obstacles to effective intervention, requiring ongoing involvement from the scientific community and healthcare professionals to promote the inclusion and well-being of people with ASD⁽⁴⁾.

Brazil still lacks detailed information on the number of people with autism and their distribution across the country. Although it is estimated that there are approximately two million individuals with ASD, this figure has not been officially recognized. To address this gap, Law 13,861, enacted in 2019, mandated that the Brazilian Institute of Geography and Statistics include ASD in the population census. The survey, initially scheduled for 2020, was postponed to 2022 due to the COVID-19 pandemic. For the first time, the census included the autistic population in its statistics, covering both those with a formal diagnosis and people who exhibit signs of the disorder but have not yet received a conclusive evaluation⁽⁵⁾.

In the context of public policy, a significant advance occurred with Law No. 12,764 of 2012, which recognized ASD as a disability. This legal milestone redefined the approach to health and rehabilitation services, expanding inclusion and the provision of specialized support. As a result, the Unified Health System began to face new challenges, such as the need to train professionals to serve this population in a more appropriate and accessible manner⁽⁶⁾.

In Brazil, Specialized Rehabilitation Centers (SRC) play a fundamental role in the assessment and rehabilitation of people with disabilities, including those with suspected ASD. A study conducted at a SRC in southern Brazil analyzed 685 medical records of children aged 0 to 12 years assessed between 2014 and 2017. The results showed that the average age of the children was 5.47 years, with 83.8% being male. The main reasons for referral were language deficits (58.8%) and externalizing behaviors (56.9%). Only 30.1% of the children had a confirmed ASD diagnosis, and the most commonly used assessment tool was the Autism Behavior Checklist (ABC), administered in 70.5% of cases⁽⁷⁾.

A study at referral centers in João Pessoa (PB - Brazil) analyzed children diagnosed after 36 months and revealed that late diagnosis is linked to difficulties in socialization, literacy, and speech, as well as impairments in attention and concentration; the study points out that the lack of early suspicion by healthcare professionals highlights the need for greater training and reinforces the importance of early diagnosis and therapeutic interventions to reduce impacts on child development⁽⁸⁾.

In light of this, the objective of this study is to describe the interdisciplinary care protocol implemented at a SRC for individuals with ASD, emphasizing early intervention practices and the active participation of families in the therapeutic process.

METHOD

Design and Setting

A descriptive, qualitative study based on a documentary analysis of the institutional care protocol for individuals with ASD at the SRC. The SRC is a referral center for multiprofessional rehabilitation within the São Paulo public health system.

The study was informed by the authors' participant observation regarding the scope of care for users with a diagnosis or suspected ASD, as well as by the health professionals directly involved in the care and follow-up of these users. The observation involved participants who were receiving care during the data collection period and who met the inclusion criteria defined for ASD care, such as age compatible with the rehabilitation services offered and the presence of an active record in the SRC system.

Data Collection

The document analysis covered the current institutional protocol, including its organizational structure, care pathways, eligibility criteria for care, available therapeutic modalities, and intersectoral coordination with other services in the healthcare network.

Data Analysis

The data were systematized and organized into thematic categories, allowing for a description of the care structure, the dynamics of therapeutic interventions, and the challenges and potential of the adopted care model.

RESULTS

Care Structure

The SRC protocol establishes a structured flow for the care of individuals with ASD, covering the following areas:

- 1. Diagnostic Process:** Interdisciplinary evaluation with professionals from various fields, including neurology, speech-language pathology, occupational therapy, and psychology.
- 2. Early Intervention:** Specialized care for children aged 0 to 3 years at risk of developmental delays, aimed at minimizing impacts on development.
- 3. Rehabilitation:** Organization of group sessions according to age group, promoting social interaction and expanding the repertoire of skills.
- 4. Family Support:** Holding periodic meetings with family members to provide guidance and support in managing ASD within the social context.
- 5. Network Coordination:** Referral of clients to other services within the health, education, and social services networks, ensuring continuity of care.

Initial Assessment Process

The purpose of the initial assessment, whether through external or internal referral, is for the multidisciplinary team to identify the patient's concerns by applying a structured assessment protocol. Based on the reported needs and concerns, and considering the context of the patient and their family, the team determines the appropriate course of action within the service, which may follow one of three approaches:

- Diagnostic process;
- Early intervention for mental health risks;
- Rehabilitation.

Diagnostic Process

The diagnostic process for patients with suspected ASD or who require a differential diagnosis involves follow-up by at least three professional categories. The multidisciplinary evaluation takes place in a group setting and/or individually, with a minimum of four sessions. In addition, a school report and referral are requested or scheduled, usually during a single session.

The neuropsychiatric evaluation includes two consultations, while referrals for further investigation, such as ophthalmology, hearing health, and additional tests, are requested as needed. After these procedures are completed, a case discussion is held to produce the multidisciplinary report, a step that requires at least one session.

It is worth noting that patients with suspected ASD may be enrolled in rehabilitation before the diagnosis is finalized, and are subsequently referred to the appropriate network as needed.

Early Intervention

Early intervention in infants aged 0 to 3 years with signs of psychological risk is essential for mental health in early childhood. Identifying difficulties in psychological and relational development requires an interdisciplinary approach, involving at least two professional disciplines, including psychology.

The process begins with a team discussion of the case, allowing for a broader perspective. Next, a family assessment is conducted to understand relational dynamics and factors influencing child development. Based on this, an Individualized Treatment Plan (ITP) is developed, which may include individual or group sessions of varying duration and periodic reassessments.

Follow-up involves regular discussions about the baby's progress, which may result in adjustments to the strategy, continuation of treatment, or discharge. The family plays a central role, participating in structured feedback sessions at key moments. This model aims to minimize impacts on child development and strengthen family bonds, fostering an environment conducive to emotional and social growth.

Rehabilitation for Individuals with ASD

The rehabilitation process for individuals with ASD at the Specialized Rehabilitation Center is primarily structured around group sessions, which may include up to five patients. However, when significant behavioral difficulties prevent initial participation in group sessions, the patient may be temporarily placed in individual therapy. One of the main objectives of this format is to subsequently facilitate the patient's inclusion in group sessions.

The ITP guides both individual sessions and shared group sessions. From the start of the process, discharge plans are established, defined in collaboration with the patient and their family. Every 12 sessions, therapeutic goals are reassessed. This protocol follows the Guidelines for the Organization of

Rehabilitation Activities in the Care Network for People with Disabilities (2022), which stipulate that at this care center (SRC), the duration of the intervention must be determined according to the achievement of the therapeutic goals established and reviewed in the ITP.

The ASD care protocol at the SRC is structured around an interprofessional and collaborative model, ensuring a comprehensive view of each individual's uniqueness. Organizing care by age groups allows for the development of therapeutic strategies focused on the development of individual functionalities and potential. This model, in addition to integrating various fields of knowledge, creates a therapeutic space that fosters social interaction, autonomy, and communication—fundamental aspects in the rehabilitation of people with ASD. These are described below:

PUPA (2 to 5 years): Focus on communication, social interaction, and initial autonomy through symbolic and functional play. Activities: music, play, food selectivity, and physical games.

LAGARTA (ages 6 to 9): Development of social and manual skills, problem-solving, and independence in Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Activities: children's cooking, gardening, and functional skills.

CASULO (ages 10–13): Emphasis on body awareness, social and emotional skills, and autonomy in daily tasks. Activities: cooking, pre-teen group, and crafts.

METAMORFOSE (ages 14–17): Development of identity, autonomy, and social relationships, with a focus on solving complex problems. Activities: teen groups and cooking workshop.

BORBOLETA (ages 18–30): Preparation for entering the workforce, strengthening independence, and personal empowerment.

Assessment Tool

Monitoring of patients' progress during the rehabilitation process is conducted using the Modified Brazilian Functionality Index (IFBr-M), the official instrument adopted by the Brazilian Government for assessing disability. Recognized by Resolution No. 01, dated March 5, 2020, of the National Council for the Rights of Persons with Disabilities, the IFBr-M is based on the psychosocial model of disability, which views functionality as the result of the interaction between an individual's health conditions and the environmental and social factors surrounding them.

Unlike purely biomedical models, which focus solely on physical or cognitive limitations, the IFBr-M broadens the assessment by considering bodily functions, the level of independence in performing activities, the degree of participation in society, and the barriers faced in daily life. This approach enables a more comprehensive view of the patient's needs, allowing the ITP to be adjusted in a more precise and effective way throughout the rehabilitation process. Additionally, the IFBr-M provides objective parameters for the multidisciplinary team, aiding in decision-making regarding interventions, necessary environmental adaptations, and strategies to promote autonomy.

Family Support

Family involvement is essential in the diagnosis and rehabilitation of infants and children with psychological risk or ASD. From the outset, the family is engaged through active listening, taking into account their perceptions and concerns, which allows for a broader understanding of the context.

During rehabilitation, caregivers receive support to understand the impact of the diagnosis and develop strategies to promote child development and social inclusion. Bimonthly meetings with the multidisciplinary team facilitate exchanges among families, adjustments to the ITP, and alignment of strategies based on the child's progress. This approach strengthens the family's role as an active partner in the process, ensuring that therapeutic gains are sustained in the child's daily life.

Network-Based Care

Care for individuals with ASD is not limited to therapies in the rehabilitation service but must be coordinated with other parts of the network, involving health, education, culture, leisure, and sports. Thus, the protocol emphasizes that rehabilitation should not restrict the individual to a clinical setting but rather enable their social participation and engagement in various contexts.

Therefore, in addition to referrals and guidance regarding network facilities, guidance and support are provided to help individuals with ASD and their families expand their activities to community settings, which rehabilitation supports by promoting outdoor activities such as outings, visits to parks, cultural centers, sports facilities, and other public spaces. These actions allow both the patient and their family to become familiar with the local area, take advantage of available resources, and understand that disability should not be a factor for social exclusion, but rather an aspect to be considered in building an active and participatory life.

This approach fosters the development of autonomy, expands opportunities for socialization, and strengthens the building of a support network that extends beyond healthcare services, ensuring broader inclusion of individuals with ASD in society.

DISCUSSION

The results presented demonstrate the structuring of ASD care at the SRC, highlighting an interprofessional and shared model focused on patients' functionality and quality of life. The organization of the care protocol, from the diagnostic phase through rehabilitation and the transition to adulthood, reflects an approach that integrates different dimensions of care, going beyond a purely clinical perspective. This model aligns with international authors and documents, such as the WHO's "Framework for Action on Interprofessional Education and Collaborative Practice"⁽⁹⁾, which emphasize that collaborative practice in health strengthens the effectiveness of services, as it involves professionals who, by working together, complement their knowledge and enhance therapeutic outcomes.

According to Beauchemin et al. (2019)⁽¹⁰⁾, the implementation of clinical guidelines in healthcare practice is a complex process that requires the integration of scientific evidence, institutional context, and professional engagement. The literature highlights that, even with the wide availability of evidence-based protocols, the expected outcomes in care quality are not always achieved due to barriers such as resistance to change, lack of training, and structural limitations in health services.

Chacarolli et al. (2023)⁽¹¹⁾, emphasize that the production of summary guidelines represents an important strategy for knowledge translation, allowing clinical protocols to be effectively incorporated into the routine of health services. This approach has contributed to the dissemination of best practices and to strengthening comprehensive care for individuals with ASD, especially in situations involving aggressive behaviors, communication, and socialization.

Early intervention is widely recognized as a key factor in minimizing the impacts of ASD on child development. Studies show that approaches initiated in early childhood, such as the Early Start Denver Model, result in significant improvements in the communication and adaptive skills of children with ASD⁽¹²⁾. Furthermore, data from the CDC⁽³⁾ emphasize that early diagnosis and intervention enable greater social integration and a reduction in functional barriers in adulthood. In Brazil, the inclusion of the family in the therapeutic process is highlighted as a necessity for integration between the health and education sectors to ensure a broader and more inclusive approach⁽¹³⁾.

Interdisciplinary care is another essential pillar of the rehabilitation model adopted by SRC. The international literature emphasizes the importance of collaboration among different specialties to optimize therapeutic outcomes, discussing the relevance of standards for interprofessional collaboration in the treatment of ASD and reinforcing that the integration of psychologists, speech-language pathologists, occupational therapists, and physicians significantly improves patient outcomes⁽¹⁴⁾. In the national context, authors demonstrate that collaborative practice in healthcare strengthens the effectiveness of services, as it allows different professionals to complement their knowledge, resulting in more accurate diagnoses and more effective therapies⁽¹⁵⁾.

Network coordination is essential to ensure continuity of care and promote social inclusion. In the study on work organization in the SRC of the city of São Paulo⁽¹⁶⁾, it is observed that, despite municipal and national guidelines, each unit structures its services in a unique way, reflecting the challenges of integration among professionals, local demands, and the healthcare network. The absence of formal spaces for case discussion and action planning compromises the effectiveness of interprofessional care. This reinforces the importance of initiatives such as the bimonthly meetings with family members at the SRC, which enable a better understanding of the therapeutic process and promote family engagement in rehabilitation.

The use of the IFBr-M in patient follow-up represents an advance in rehabilitation assessment, as it allows for consideration not only of clinical aspects but also of social and environmental barriers. This assessment model aligns with international approaches that seek to integrate the individual's functionality into the social context, broadening the understanding of the challenges faced by people with ASD and enabling more effective adjustments to the ITP.

Rehabilitation prior to a definitive diagnosis reinforces early intervention, minimizing impacts on child development and promoting interprofessional follow-up from the earliest years. Family involvement is essential for better therapeutic outcomes, with the ITP being adjusted according to the patient's progress. Group therapy promotes social interaction and skill development, while age-grouped structures allow for a progressive approach, respecting the needs of each stage, from childhood to adulthood⁽¹⁷⁾.

In addition, therapeutic groups provide a safe and structured environment for children with autism to practice social behaviors, which contributes to reducing challenging behaviors and strengthening self-esteem⁽¹⁸⁾. These interventions not only enable the practice and reinforcement of individual skills but also foster the exchange of experiences among participants, creating a support network that can enhance patients' autonomy and social integration.

The duration of rehabilitation follows guidelines based on periodic reviews of therapeutic goals, ensuring that care is focused on the patient's actual needs and avoiding prolonged dependence on specialized services. This aspect is consistent with rehabilitation principles based on functionality and social inclusion, prioritizing the transition to community-based activities and services.

Thus, it is evident that the process of implementing clinical protocols for ASD care at the SRC goes beyond mere adherence to technical recommendations. It requires **ongoing staff training, institutional support, monitoring of outcomes, and periodic review of the practices adopted**, in line with the principles of evidence-based care. The integration of public policies and clinical practices promotes comprehensive, humanized care centered on the needs of individuals with ASD and their families.

CONCLUSION

The SRC's interdisciplinary care protocol has established itself as a fundamental strategy for providing qualified care to individuals with ASD, enabling structured therapeutic interventions and continuous support for families. The coordination among different specialties allows for a broader view of users' development, ensuring more integrated and effective approaches. Furthermore, the standardization of care pathways and the strengthening of the care network expand opportunities for social inclusion, promoting greater autonomy and quality of life for patients.

The results obtained demonstrate the importance of continuing and improving institutional strategies, with investments in professional training, expanding access, and strengthening the support network for families. In this way, not only is the quality of care maintained, but the positive impact of this care model is also expanded, fostering the development of a more efficient and humanized rehabilitation system.

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Transparency in authors' contributions according to the [CRediT Taxonomy](#).

Conceptualization	Ana Paula Ribeiro Hirakawa
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