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Montana Access to Pediatric Psychiatry Network

Autism

Project ECHO

Billings Clinic Foundation

PublicHealth IN THE 406

MONTANA CHILDREN'S SPECIAL HEALTH SERVICES

Rural Institute UNIVERSITY OF MONTANA

Modified from Seattle Children's Hospital -https://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/resources/

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Considering an Autism Spectrum Disorder?

Any Early Red Flags?

- Not smiling in response to being smiled at, or making eye contact
- Does not develop shared attention with others
- Does not respond to own name by 1 year of age
- Poor social communication or lack of interest in other children

Consider a comorbidity or other diagnoses:

- Intellectual Disability (ID), Global Developmental Delay (GDD), Learning Disorders Speech and Language Disorders
- Hearing or Vision Impairment
- Neglect or Abuse
- Other Neurologic Disorders (epileptic, infectious, auto-immune, neoplastic, metabolic)
- Other Psychiatric Disorders (Anxiety, Depression, ADHD)

Diagnosis: Use DSM-5 diagnostic criteria which include presence or early developmental history of:

1. Impairments in Social Communication and Social Interaction — three domains of impairment in this area should include A) deficits in social-emotional reciprocity, B) deficits in nonverbal communication for social interaction, and C) deficits in developing, maintaining, and understanding relationships.
2. Restrictive, repetitive, patterns of behavior, interests or activities — including at least two of the following domains of A) stereotyped/repetitive movements, use of objects or speech, B) insistence on sameness, inflexible routines, ritualized patterns of behavior, C) highly restricted, fixated interests of abnormal intensity or focus, D) hyper or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment

May augment one's assessment with an age-appropriate screening tool:

M-CHAT-R/F (Modified Checklist of Autism in Toddlers) for age 16-30 months.
Found at http://mchatscreen.com

CAST (Childhood Autism Spectrum Test) for age 4-11 years, and AQ (Autism Quotient) for age 12-15 years.
Found at www.autismresearchcentre.com/arc_tests

Treatment:

Referral for further evaluation, Early Intervention and education:

- If birth to three years old: In a child with concerns about autism or other developmental delays, you first refer to early intervention. Montana is divided into several regions which can be found on the MT DPHHS website (Montana Milestones Part C Early Intervention Program).
- If three to five, then contact your local school district. They will usually refer you to the next preschool screening. Many children with autism are overwhelmed with this setting and you may need to advocate for another means of evaluation.
- If in school, then help the parent to advocate for an IEP evaluation. The IDEA regulations indicate that either the parent of a student, or a public agency, may initiate a referral for an initial evaluation.

Individually evaluate. Address any deficits in the following areas

- By definition, all children with autism have deficits in social language, so referral to speech therapy is usually indicated, if available
- Sensory sensitivities/emotional regulation deficits or motor abnormalities that impact function: consider referral to an occupational therapist
- Maladaptive Behavior that affect function: referral to a behavior therapist, psychologist or psychiatrist
- ABA: if available, Applied Behavioral Analysis, if available, for significantly affected children

Medical Evaluation:

- Check hearing and vision. Check on dental status. assure getting routine medical care.
- Consider epilepsy if concerning symptoms, or decline in functioning
- Do genetic, metabolic, or other studies as indicated by functioning. If the child shows significant delays, then, in general, microarray and fragile X testing are indicated. Consider referral to Shodair Genetics (406-444-1016).
- Monitor closely for treatable medical problems like ear infections, constipation or anemia which can worsen functioning.
- Consider co-morbid psychiatric conditions which are very common such as ADHD , Anxiety, depression and sleep disorders. These can worsen functioning.

Recommended Reference: Identification, Evaluation, and Management of Children With Autism Spectrum Disorder Susan L. Hyman, Susan E. Levy, Scott M. Myers ;Pediatrics January 2020, 145 (1) e20193447; DOI: https://doi.org/10.1542/peds.2019-3447

Primary References:

Johnson C, Myers S, Council on Children with Disabilities, "Identification and Evaluation of Children with Autism Spectrum Disorders," Pediatrics 120(5): November 2007: 1183-1215.

Myers S, Johnson C, Council on Children with Disabilities, "Management of Children with Autism Spectrum Disorders," Pediatrics 120 (5), November 2007: 1162-1182.

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Treatments for Autism and Difficulties Associated with Autism

Treatment for Autism:
- Currently, there is no single treatment for autism, but a variety of approaches may fit the child's unique circumstances.

Speech and Language Therapy:
- Consider when communication is a key concern. Goal is to teach pragmatic or social language skills, rewarding any steps child makes in this direction. Alternative communication systems like Picture Exchange Communication System (PECS) may be needed if child remains non-verbal. The picture exchange system lets the child and others point to pictures representing things (like food) or activities (like using the bathroom) to communicate. Achieving a means of basic communication is often essential in improving function and reducing maladaptive behaviors.
- Speech/Language therapists are commonly available in most communities and/or schools.

Social Skills Training:
- Consider when this is appropriate to the child's developmental level. Social skills training often uses social stories, role-playing, and peer skills groups. Social stories are cartoon-like illustrations depicting social events (e.g., greeting new people, going to the store) or skills (e.g., asking for help when teased or distressed) to help children anticipate new events or practice skills. Social skills training may become a primary focus of the school environment to teach steps of how to interact with others, especially after basic communication skills are learned.
- May be available in communities and schools through the work of Speech and Language or other therapists.

Occupational and Physical Therapy:
- Consider when there are functional problems with adaptive skills or with muscle control. Occupational therapists (OTs) are often effective in improving function impaired by sensory sensitivities by modifying the environment. OTs may also assess and work on improving adaptive skills or skills of daily living. Physical therapists (PTs) can be helpful if the child has muscle control abnormalities which impair function.
- OT and PT providers are commonly available in communities

Medical Assessment:
- Consider medical, neurological, psychiatric, medication-induced, and trauma-related causes of maladaptive behaviors, especially if there are sudden changes in function. Rule out pain (head or ear aches, constipation) as a trigger for any new behaviors, particularly since children with autism are not typically very good at communicating distress and may exhibit maladaptive behavior when medically distressed.

Behavior Therapy:
- Consider addressing core deficits associated with autism and to reduce maladaptive behaviors. Intensive behavioral therapy and related training methods (which are the components of Applied Behavior Analysis or "ABA") have been shown to improve many autism symptoms by teaching and reinforcing social and communication skills and by reducing maladaptive behaviors. Any behavioral program should be tailored to a child's needs, build on the child's interests, offer a predictable schedule, teach tasks as a series of simple steps, actively engage the child's attention in structured activities, and provide regular reinforcement of behavior. Efficacy of interventions should be tracked by establishing a baseline and monitoring progress, with interventions adjusted accordingly. Parental involvement is a major factor in treatment success —parents help identify target skills and behaviors, and are often trained to continue the therapy at home.
- Maladaptive behaviors can be reduced via a functional analysis of behavior, which includes characterizing the behavior, the setting, provoking, and reinforcing factors. The behavior is then modified by changing these factors. See also "Treating Maladaptive Behavior Using Functional Analysis," and "Autism Resources: Information for Families."
- Behavior therapists may be available in either a school or in the community.

Psychotropic Medications:
- If aggression, self-injury, irritability, or mood swings are severe, consider psychotropic medications, see page 7.

Co-morbid Psychiatric Disorders:
- Conditions such as ADHD, anxiety or depression do occur in children with autism, but avoid attributing core autism spectrum symptoms (e.g., poor eye-contact, flat affect, social withdrawal, repetitive behavior, rigidity, or concrete thought process) to a psychiatric diagnosis without noting if there had been a change from baseline. Use evidenced-based therapies for psychiatric disorders to the extent they are developmentally appropriate. Consider psychotropic medications when appropriate for a condition, but first review "Psychotropic Medication Considerations for Children with Autism."

A. A. Golombek, MD and Robert Hilt, MD

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Treating Maladaptive Behavior for the Developmentally Disabled Using Functional Analysis

Identify the behavior

Character	*(what they do)*
Timing	*(especially noting provoking and reinforcing factors)*
Frequency	*(times per day or per week)*
Duration	*(i.e. 30 minute behaviors are different than 30 second behaviors)*

Analyze and make hypotheses about the function of the behavior

- *Communication.* This is the primary etiology to investigate if a child lacks communication skills. Maladaptive behavior may communicate physical discomfort like pain, constipation, reflux or a new illness. It may also communicate an emotional discomfort like boredom, anxiety, anger, frustration, sadness, or over-excitement.
- *Achieving a goal.* How does performing the behavior benefit the child, what does he/she gain? This might include escaping an undesired situation, avoiding a transition, acquiring attention, or getting access to desired things like toys or food.
- *No function.* If there is no function identifiable for the behavior, this suggests causes like seizures, medication side effects, sleep deprivation, and other medical or psychiatric disorders.

Modify the environment by changing provoking and reinforcing factors

- Enhance communication—consider using an alternative communication system, such as a picture-exchange communication system (PECS) for non-verbal children.
- Use simple, concrete sentences and questions with child. Remain calm.
- Increase structure — provide schedule of day's events, use routines, anticipate transitions. Consider social stories to practice routines, especially to prepare for new situations. Teach the child how to ask for help and how to tell adults when they need a break.
- Modify demands — match the task to their IQ, developmental stage & language ability. Limit time for tasks, schedule fun activities after less preferred ones.
- Allow child access to a time-limited escape to a calm, quiet place if overwhelmed.
- Reinforce positive behavior with attention and praise, find out what child finds rewarding (special activity, food, favorite toy, a gold star, etc.)
- Avoid reinforcing maladaptive behavior with attention or other gains.
- Schedule special, non task-driven, time for child and parents together that is honored and not conditional on other behaviors.

Consult with a behavioral specialist to facilitate process and support family

- Behavior modification specialists can make tailored suggestions for the family's situation.
- If behavior is at school, consult with the school psychologist for a behavioral intervention.

If strategies are insufficient or behavior is severe, or places child or others at risk of harm, consider augmentation with medications

- See Care Guide sections, "Psychotropic Medication Considerations in Children with Autism" and "Non-Specific Medications for Disruptive Behavior and Aggression.

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Applied Behavioral Analysis (ABA) Tip Sheet

What is ABA?

ABA is a type of therapy that helps children improve communication and social skills as well as decrease or eliminate a range of problematic behaviors. Applied Behavior Analysis focuses on understanding behavior as a function of an individual's environment and then modifying behavior to achieve a range of goals. ABA uses the principles of learning to teach skills that improve behavior and communication related to core impairments associated with autism. ABA has the most empirical support of any treatment for autism spectrum disorder (ASD). It is also very time and labor intensive and very expensive.

What behaviors or skill deficits can be addressed with ABA?

ABA techniques have been shown to have efficacy for specific problem behaviors as well as academic tasks, adaptive living skills, communication, social skills, and vocational skills. In framing the need to parents, schools or an insurance company, consider both the need for *skill acquisition* and/or *reducing problem behaviors as goals.* Skills that can be improved include functional communication, social interaction, flexibility in play, frustration tolerance, self-care, affect regulation and relaxation strategies. Common behavioral targets include tantrums, physical aggression, property destruction, self-stimulation, pica, elopement/escape behaviors, and inappropriate social interactions/boundaries. Because most children with ASD tend to learn tasks in isolation, generalization beyond an ABA setting is an important goal.

How do I help my patient and families access ABA?

The route to receiving ABA therapy varies depending on the type of insurance coverage, but it generally begins with a referral to, and evaluation by, an approved provider. Which individual or disciplines have been "approved" for determining the appropriateness of ABA varies by insurance carrier. It can be a challenging process to get a prescription for ABA and locate a provider who does this work, however, coverage is beginning to improve.

What if my patient is covered by a Medicaid?

Medicaid does sometimes cover ABA but the coverage is limited and restricted to the most affected. Your ABA provider can apply for preapproval.

What if my patient is covered by private insurance?

Under Brandon's law,(2010) health care plans that are based in Montana must pay for autism spectrum disorders for children less than 19. There is a maximum benefit for ABA of $50,000 under age 9 and $20,000 ages 9-18. This includes rehabilitative care, medication, psychiatric or psychological care. Tricare and some other plans cover autism services as well.

Psychiatric Medication Considerations for Children with Autism

- Medications do not improve core autism features; *i.e. there is currently no "autism medication."*
- Consider augmenting behavioral or counseling treatments with medications if there is moderate to severe distress and dysfunction in an area noted to be medication responsive.
- Use a single medication appropriate to a diagnosis or target symptom. Start low and increase slowly.
- Track the target symptom's response to interventions.
- Be skeptical about the utility of medicines that "work" for only a couple of weeks before a dose increase seems to be required — it is not safe to increase medicine doses indefinitely beyond the normal dosage range.
- If an intervention isn't reducing symptoms, taper and remove the medication, then reevaluate. Be vigilant about stopping any medication that is not clearly helpful.
- A history of past benefit from a medication does not necessarily mean there is continued benefit from ongoing use. Periodic attempts to wean off a previously helpful medication (such as annually) will reveal if ongoing use of that medicine is desirable.
- Do not exceed maximum dose recommendations for typically developing children. Note children with autism typically experience more adverse effects than others do from psychotropic medications.
- **Children with autism often experience more adverse effects than others do from psychotropic medications. Start low, go slow and do not exceed maximum dose recommendations for typically developing children.**

ADHD:

Consider stimulants if an ADHD comorbidity, though they may have less benefit on ADHD symptoms than children without autism. They also have more adverse effects than children without autism, including more irritability, insomnia and social withdrawal.

If hyperactivity and impulsivity are the main issues, consider guanfacine or very low dose clonidine (both have long acting forms if the child can swallow pills). The main side effects are sleepiness and potentially irritability.

Anxiety:

Many children with autism are anxious. This may lead to reactive, emotional outbursts. SSRIs, often at very low doses, can improve behavior and function. They have a better side effect profile than Antipsychotics, but have a higher rate of adverse effects including agitation, irritability, elation and insomnia than for children without autism.

Irritable, Aggressive Behavior:

Risperidone and Aripiprazole are both FDA approved for children (Risperdal 5-17; aripiprazole 6-17) with irritability, aggression, self injury and quick mood swings associated with autism. These can be used if behavioral therapy is yielding inadequate results on severe symptoms. However consider the above medications first. The Antipsychotics have many adverse effects including weight gain, dystonia, sedation, neuroleptic malignant syndrome, tardive dyskinesia and both cholesterol and glucose elevations. Start with very small doses and increase slowly – Risperidone should be started at 0.25 mg/day and usual effective dose is less than 2 mg/day. Abilify is effective at 2-15 mg a day. These require glucose, lipid panel and AIMS monitoring.

If your patient is on Medicaid and under eight, to place them on antipsychotics, you will need to fill out a form which includes a fasting blood sugar and lipids and informed consent signed by legal guardian and prescriber. You can get the form from the Drug Prior Authorization Unit at 406-443-6002 or 800-395-7961.

Autism Resources

Information for Families

Books (Where to start!):

- Children with Autism: A Parent's Guide (2000) by Michael Powers
- Autism Spectrum Disorder, 2nd edition (2019) AAP-Rosenblatt and Carbone
- An Early Start for Your Child with Autism: Using Everyday Activities to Help Kids Connect, Communicate and learn (2012) by Rodgers, Dawson et al
- A Parent's Guide to Asperger Syndrome and High Functioning Autism: How to Meet the Challenges and Help Your Child Thrive (2015) Ozonoff, Dawson and McPartland

Websites families may find helpful:

- Autism Speaks (www.autismspeaks.org) (advocacy, diagnostic, treatment and support resources)
- Montana Rural Institute Autism Center (http://autism.ruralinstitute.umt.edu)
- Montana Autism Advocacy Facebook page
- Medical Home Portal (https://mt.medicalhomeportal.org) list of Montana resources for children with a special needs
- Montana PTI (formally PLUK) for parent resources now (www.MontanaPTI.org) or 1-877-870-1190

Resources for Teaching Social Skills

All Ages:

- The Social Skills Picture Book: Teaching Play, Emotion, and Communication to Children with Autism (2003), by Jed Baker (Future Horizons)
- The New Social Story Book, Illustrated Edition (2000), by Carol Gray (Linguisystems)

Preschool-Kindergarten:

- Skillstreaming in Early Childhood: Teaching Prosocial Skills to the Preschool and Kindergarten Child (1990), book and program forms booklet, by Ellen McGinnis and Arnold Goldstein (Research Press)
- Do, Watch, Listen, Say (2000), by Kathleen Ann Quill (Thinking Publications)

Elementary Grades (1st through 4th):

- Social Star: General Interaction Skills (Book 1), Social Star: Peer Interaction Skills (Book 2), and
- Social Star: Conflict Resolution and Community Interaction Skills (Book 3), by Nancy Gajewski, Patty Hirn, and Patty Mayo (Thinking Publications)
- Skillstreaming the Elementary School Child: New Strategies and Perspectives for Teaching Prosocial Skills (1997), by Ellen McGuinnis and Arnold Goldstein (Research Press)
- Comic Strip Conversations (1994), by Carol Gray (Thinking Publications)

Secondary Grades and Adolescents:

- SSS: Social Skills Strategies Book A and SSS: Social Skills Strategies Book B (1989), by Nancy Gajewski and Patty Mayo (Thinking Publications)
- Navigating the Social World: A Curriculum for Individuals with Asperger's Syndrome, High Functioning Autism and Related Disorders (2001), by Jeanette McAfee, MD (Future Horizon)
- Inside Out: What Makes the Individual with Social-Cognitive Issues Tick? (2000), by Michelle Garcia Winners (Thinking Publications)

Board Games and Online Games:

- 10 Say and Do Positive Pragmatic Game Boards (Super Duper Publications)
- The Non-Verbal Language Kit (ages 7-16, Linguisystems)
- http://do2learn.com (free games that teach about feelings and facial expressions)

Picture Exchange Communication System (PECS) resource:

- http://do2learn.com (has pictures that can be printed out for arranging a visual daily schedule)

This resource page is now available in Spanish at www.seattlechildrens.org/pal

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This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $2.2MM with 25% financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.