OLSON HUFF CENTER NURSING RESOURCES

EFFECTIVE COMMUNICATION PROTOCOLS FOR OHC NURSING STAFF

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NEEDS ASSESSMENT

What training in DBPeds content is needed for nurses in the Huff Center?

Information from nurses who have worked in the office

Information on medications used in the office. What they are, what conditions are they used for and what are the common side effects

Knowing the resources to share with families. It would be helpful to “get the numbers and Information out of Katrina’s brain”. Mobile crisis number, info on what agencies are in what area, etc.

Training on how to communicate most efficiently with providers and what and how to document

Knowledge of clinical conditions, e.g., ADHD, autism, sensory issues and LD

Learning to look at the big picture such as looking at sleep, appetite and general health and how it is affecting the child

Understanding what is needed to get a PA for medicine and what medicines are covered by what insurance

Input from providers

Nurses need a good knowledge base so to be able to find out information needed by providers to make a decision

Standardized approach to phone calls with protocols for different scenarios

Efficient use of nursing time and recognizing when someone needs to get an appointment with a provider and when it can be handled on the phone by the nurse or by talking with the provider

Clear and concise documentation/knowing what should and shouldn’t be put in the chart

Nurses need to be aware of who is the LCSW on call, how to contact them, and when to put the family in contact with them

Nurses need to know the red flags indicating a need for emergency intervention: Suicide threat with a plan and/or a means Past history of suicide attempt or self-harm Family history of suicide or attempts Exposure to a recent suicide
Nurses need to know resources in cases involving threats of self-harm or harm to others

**NAVIGATING THE EMR AT THE OLSON HUFF CENTER**

**How to Locate Olson Huff Center Information in EMR**

In left hand column, click on “Power Note” tab: Once notes populate, identify the following:

- “Facility” Heading: Indicating “Olson Huff”
- “Subject” Heading: Identified by: “Office Visit Note/Specialty Office Visit Note”
  - “Med Management” (Refills)
  - Triage Calls
- “Author” Heading: OHC Providers, Nurses, or other OHC support staff

**How to Communicate with Providers**

Open patient chart and start a “communication” note on a phone encounter

Gather information from the caller:

- Obtain name/relationship/phone number of the caller
- Concerns
- Detailed description of concerns
- Medications/Dosage
  - If refill needed: How is child doing on the medication, when is the next appointment, are provider recommendations being followed, etc. (there is a protocol driven order in place for refills)
  - Send message to provider and once response is received, contact caller with recommendations.
Thank you for the consistent and wonderful care that you provide for our children and families. These guidelines are here to support the quality care that you provide to our patients and families.

1. Introduction

Remember that you are a critical part of the child's care team. The caregiver's interaction with you goes much further than simply a means of relaying information to a provider. You are on the front line, often meeting the family when they are in the deepest crisis. The relationship that you build and the caring atmosphere that you create absolutely impacts patient outcomes. When you are able to provide a genuinely compassionate and kind exchange, you enhance caregiver confidence, allow them to relax, and model for them how to support their own child during a stressful exchange.

To this end, the greeting is important. Remember to relax before you pick up the phone or return a call. Smile, introduce yourself (including your title), and know that you are making a difference.

2. Remember…

- We all communicate in different ways; we all have different backgrounds; some people understand our language, some people do not.

- When we are stressed, our ability to process and retain information diminishes.

- The PEARLS of Relationship Centered Care: Partnership, empathy, apology, respect, legitimization, support.

3. Demographics

Collect or confirm demographics: Name, date of birth, gender, phone number and name and relationship of the caller.

4. Identify the caller's concern

Is the concern life-threatening?
Is the child and caregiver safe?

5. Obtain a brief health history

Briefly clarify diagnoses, provider, recent visits/hospitalizations, medications and current therapies.


Listen not only to the words that the caller uses, but also to the tone and intensity of voice. Listen to your own judgment and intuition. What other messages are conveyed? What is unsaid? You have powerful clinical judgment that may speak to you from your "gut." Never ignore this.

7. Identify the main category of the concern
Is this a Behavioral Concern?
Is this a Medication Concern?
Is this a New Clinical Concern?
Is this a Care Coordination Concern?

8. Follow the Protocol (loosely)

Behavioral concerns
Examples:
Externalizing behaviors—aggression, irritability, acting out
Internalizing behaviors—withdrawal, anxiety/panic, depression
Suicidal ideation

Protocol/sample questions:
Give me an example...
How often?
Severity?
Setting?
Aggravating or relieving factors?
Associated factors—recent change, associated illness?
Caregiver’s perception of the problem?

Medication concerns/questions
Examples:
Appetite concerns
Sleep concerns

Protocol/sample questions
Review medications
Adherence to medication regimen?
Changes in medication regimen?
Associated symptoms?
Other recent changes, stress, exposures?

New clinical concerns/symptoms
Examples:
Constipation
Tics
Rash

Protocol/sample questions
Define concern
Severity?
Timing (onset, duration, frequency)?
Setting?
Aggravating or relieving factors?
Associated factors—recent change, associated illness?
Caregiver’s perception of the problem?
Review medications
Adherence to medication regimen?
Changes in medication regimen?
Seen primary care provider?

Care coordination
Examples:
Appointments
School issues
Insurance questions

Protocol/sample questions
Define concern
Caregiver’s perception of the problem?
Caregiver solutions?
How can I help?

9. Select appropriate disposition
911
Rapid response team
Immediate conversation with provider
EMR message
Resolution by nurse

10. Communicating provider response
Utilize appropriate care response resources
Verify understanding—use teach back method
Give call back instructions
Thank the caregiver for their call.
Relationship Centered Care

Physicians, allied health staff and patients CONNECTING through

P E A R L S

Partnership
"Let's tackle this together."

Empathy
"That sounds hard."
"This must be difficult for you."

Apology
"I am sorry that this process is taking so long."

Respect
"I appreciate your decision."

Legitimization
"Anyone would be concerned by this situation."

Support
"I'll be here if you need me."
Coping Skills

**Self-Soothing**  
(Comforting oneself using the 5 senses)

Examples:
- Hugging a stuffed animal
- Listening to music
- Smelling a candle or spraying perfume
- Drinking tea
- Looking at the nature

**Distraction**  
(Taking your mind off the problem)

Examples:
- Reading a book
- Doing a puzzle
- Making art
- Watching a movie

**Opposite Action**  
(Engaging in the opposite of your impulse to promote more positive emotions)

Examples:
- Reaching out to a friend
- Making a list of affirmations
- Watching a funny TV show
- Taking a walk

**Emotional Awareness**  
(Identifying and expressing your feelings)

Examples:
- List out your emotions
- Write in a journal
- Paint or draw how you are feeling

**Mindfulness**  
(Centering and grounding oneself in the present moment)

Examples:
- Meditate
- Engage in breathing exercises
- Practice yoga

**Crisis Plan**  
(Contact info of supports and resources, for when coping skills aren't enough)

Examples:
- Family/Friends
- Therapist/Psychiatrist
- Hotline
- Mobile Crisis Team/ER
- 911
Coping Skills Wheel
9 Ways to Handle Big Emotions

- Get A Drink
- Read A Book
- Listen To Music
- Color Or Draw
- Exercise
- Count Slowly
- Talk To An Adult
- Take A Break
- STOP

Created by: GourmetChesley
SUICIDE RISK ASSESSMENT

At Mission we use a Care Process Model to help “systematic treatment processes across all hospital and practices, improving consistency as well as effectiveness.” (Care Process Model: Suicide Assessment, 8/92017, p. 3.)

Importance of Risk Assessment

7% of patients in Mission Hospital Inpatient psychiatric units and holding areas have constant suicidal ideation; 27% have intermittent suicidal ideation (October 2017-May 2017).

Suicide is exceedingly rare before puberty, but becomes increasingly more frequent through adolescence. The overwhelming proportion of adolescents who commit suicide (over 90 percent) suffered from a psychiatric disorder at the time of their death. Over half had suffered from a psychiatric disorder for at least two years.

Relevance of Risk Assessment to our population of persons with ASD and/or intellectual disability:

- Impairment in social communication is associated with an increased risk of suicidal thought, suicidal plan, and self-harm with suicidal intent in persons with autism in later adolescence
- Difficulty establishing interpersonal relationships can be triggers for suicidal behavior.
- Adolescents with ASD without intellectual disability may be most at risk of suicidal ideation and behavior due to increased awareness of their social difficulty and depression secondary to social isolation and exclusion.

Screening calls for Suicide risk

The goal is to determine basic information that can help with decision making. If the parent/caregiver discusses concerns about the individual showing recent changes in behavior, this might lead to discussion about the child/adolescent’s safety.

Initially offer suggestions for help:

1) School counselor
2) Primary care provider
3) Faith-based resources (minister/priest)

If concern is raised about hurting self/suicide, then a brief risk assessment can be performed. Ask questions about:

1) Thoughts of hopelessness
2) Thoughts of wishing to be dead
3) Thoughts of suicide
4) A stated suicide plan
5) History of previous attempts
6) Access to firearms
Major risk factors include:

- A previous suicide attempt (regardless of how serious)
- Experiencing a serious loss (e.g., end of a personal relationship, a job, the death of somebody very close, etc.)
- A family history of suicide
- A history for abuse or family violence
- A severe depressive episode
- Suffering from long-term depression or another serious mental illness
- Having a dual diagnosis (i.e., a psychiatric/substance use disorder and developmental disorder)
- Using/abusing alcohol or drugs
- A severe disabling and/or chronic illness and/or severe pain
- Being arrested or imprisoned

The following are warning signs of suicidality in teens:

- Threatening to complete suicide or harm him/herself in some way
- Having a plan for completing suicide
- Acquiring the means to complete suicide (e.g., stockpiling pills, taking possession of a gun, etc.)
- Rehearsing the act of suicide
- Having feelings of hopelessness
- Talking about, writing about, or drawing about death
- Withdrawing from social activities, ties, or relationships
- Losing interest in normal pleasurable activities, and every activities
- Giving away important personal items
- Undergoing significant changes in personality and mood

A teen who is contemplating suicide may also:

- Complain of being “rotten inside”
- Give verbal hints with statements such as “I won’t be a problem for you much longer”, “Nothing matters”, “It’s no use” or “I won’t see you again”
- Put his or her affairs in order—for example, giving away personal possessions, cleaning his or her room, throwing away important belongs, etc.
- Become suddenly cheerful after a period of depression (because now a solution has been determined to end the pain and sadness)

Gathering this information from the parent/caregiver will be important information when referral is made to one of our behavior health professionals here at Olson Huff Center. They will be able to administer the Columbia-Suicide Severity Rating Scale (C-SSRS) that is used at Mission to look at suicide risk more formally.

Resources for behavioral health: See county-by-county list
Avery County

If you have NC Medicaid or NC Health Choice and would like to set up an intake for mental health/behavioral health services, you can do so by calling Vaya Health (previously called Smoky Mountain Center) at 1-800-849-6127.

A customer service representative will connect you with a provider who accepts Medicaid and can offer services to your child based on their situation.

Typically, an assessment will be done first to determine the level of care that your child will need. Then, they will have an appointment with the clinician who will be working with them regularly.

If you have a preference for a specific provider, you may also call them directly to set up intake. Many providers have walk-in hours for the initial assessment.

For Avery County, providers who see children include:

Daymark Recovery Services- 828-733-5889

**If there is a behavioral or mental health crisis before you establish care with a provider, please call Mobile Crisis at 888-573-1006. There is no charge for this service.**

If you or your child is in immediate danger, is having a medical emergency, or is threatening themselves or others please call 9-1-1. **

The Lifeline- 24/7 support for people experiencing emotional crises. You can call the lifeline at 1-800-273-8255, or go on their website to live chat. [https://suicidepreventionlifeline.org/](https://suicidepreventionlifeline.org/)

Please do not hesitate to call Sarah Kirkpatrick, LCSW, LCAS with Mission Children’s Specialists at 828-213-1869 if you have any trouble setting up services.
**Buncombe County**

If you have NC Medicaid and would like to set up an intake for mental health/behavioral health services, you can do so by calling Vaya Health (previously called Smoky Mountain Center) at 1-800-849-6127.

A customer service representative will connect you with a provider who accepts Medicaid and can offer services to your child based on their situation.

Typically, an assessment will be done first to determine the level of care that your child will need. Then, they will have an appointment with the clinician who will be working with them regularly.

If you have a preference for a specific provider, you may also call them directly to set up intake. Many providers have walk-in hours for the initial assessment.

In Buncombe County, providers who see children include:

Family Preservation Services- (828) 225-3100

RHA, Inc. 1-800-254-2700

Universal- (828) 225-4980

Caring for Children- (828) 298-0186, www.caring4children.org

Carolina Outreach- (828) 505-1762, www.carolinaoutreach.com

*There are many other individual practitioners in Buncombe County for outpatient therapy only- please ask Vaya Health about this if you are interested.*

**If there is a behavioral or mental health crisis before you establish care with a provider, please call Mobile Crisis at 888-573-1006. There is no charge for this service.**

You may also receive walk-in crisis services at RHA’s C3-356 located at 356 Biltmore Ave, Asheville, NC 28801 24 hours per day.

If you or your child is in immediate danger, is having a medical emergency, or is threatening themselves or others please call 9-1-1. **

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Please do not hesitate to call Sarah Kirkpatrick, LCSW, LCAS with Mission Children’s Specialists at 828-213-1869 if you have any trouble setting up services.
Burke County

If you have Medicaid and would like to set up an intake for mental health/behavioral health services, you can do so by calling Partners Behavioral Health Management at 888-235-4673.

A customer service representative will connect you with a provider who accepts Medicaid and can offer services to your child based on their situation.

Typically, an assessment will be done first to determine the level of care that your child will need. Then, they will have an appointment with the clinician who will be working with them regularly.

If you have a preference for a specific provider, you may also call them directly to set up intake. Many providers have walk-in hours for the initial assessment.

For Burke County, providers who see children include:

FOCUS Behavioral Health Services- 828-439-8191
A Caring Alternative- 828-437-3000
Catawba Valley Behavioral Healthcare- 828-438-6226
One Love Periodic Services- 828-433-4567
Universal- 828-759-2228

There may be other individual practitioners in Burke County for outpatient therapy only- please ask Partners about this if you are interested.

**If there is a behavioral or mental health crisis before you establish care with a provider, please call Mobile Crisis at 888-573-1006. There is no charge for this service.**

If you or your child is in immediate danger, is having a medical emergency, or is threatening themselves or others please call 9-1-1. **

The Lifeline- 24/7 support for people experiencing emotional crises. You can call the lifeline at 1-800-273-8255, or go on their website to live chat. https://suicidepreventionlifeline.org/

Please do not hesitate to call Sarah Kirkpatrick, LCSW, LCAS with Mission Children’s Specialists at 828-213-1869 if you have any trouble setting up services.
**Catawba County**

If you have Medicaid and would like to set up an intake for mental health/behavioral health services, you can do so by calling Partners Behavioral Health Management at 888-235-4673.

A customer service representative will connect you with a provider who accepts Medicaid and can offer services to your child based on their situation.

Typically, an assessment will be done first to determine the level of care that your child will need. Then, they will have an appointment with the clinician who will be working with them regularly.

If you have a preference for a specific provider, you may also call them directly to set up intake. Many providers have walk-in hours for the initial assessment.

**If there is a behavioral or mental health crisis before you establish care with a provider, please call Mobile Crisis at 888-573-1006. There is no charge for this service.**

If you or your child is in immediate danger, is having a medical emergency, or is threatening themselves or others please call 9-1-1. **

**The Lifeline-** 24/7 support for people experiencing emotional crises. You can call the lifeline at 1-800-273-8255, or go on their website to live chat. [https://suicidepreventionlifeline.org/](https://suicidepreventionlifeline.org/)

Please do not hesitate to call Sarah Kirkpatrick, LCSW, LCAS with Mission Children’s Specialists at 828-213-1869 if you have any trouble setting up services.

**Cherokee County**

If you have Medicaid and would like to set up an intake for mental health/behavioral health services, you can do so by calling Partners Behavioral Health Management at 888-235-4673.

A customer service representative will connect you with a provider who accepts Medicaid and can offer services to your child based on their situation.
Typically, an assessment will be done first to determine the level of care that your child will need. Then, they will have an appointment with the clinician who will be working with them regularly.

If you have a preference for a specific provider, you may also call them directly to set up intake. Many providers have walk-in hours for the initial assessment.

If you are a member of the Eastern Band of Cherokee Indians, you may call Juvenile Services to connect with counseling services. 828-359-6835

**If there is a behavioral or mental health crisis before you establish care with a provider, please call Mobile Crisis at 888-573-1006. There is no charge for this service.**

If you or your child is in immediate danger, is having a medical emergency, or is threatening themselves or others please call 9-1-1. **

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Please do not hesitate to call Sarah Kirkpatrick, LCSW, LCAS with Mission Children’s Specialists at 828-213-1869 if you have any trouble setting up services.

Graham County

If you have NC Medicaid and would like to set up an intake for mental health/behavioral health services, you can do so by calling Vaya Health (previously called Smoky Mountain Center) at 1-800-849-6127.

A customer service representative will connect you with a provider who accepts Medicaid and can offer services to your child based on their situation.

Typically, an assessment will be done first to determine the level of care that your child will need. Then, they will have an appointment with the clinician who will be working with them regularly.

If you have a preference for a specific provider, you may also call them directly to set up intake. Many providers have walk-in hours for the initial assessment.

In Graham County, the comprehensive care provider is:

Appalachian Community Services- 828-837-0071

Family Preservation Services- 828-255-8225
**If there is a behavioral or mental health crisis before you establish care with a provider, please call Mobile Crisis at 888-573-1006. There is no charge for this service.**

If you or your child is in immediate danger, is having a medical emergency, or is threatening themselves or others please call 9-1-1. **

The Lifeline- 24/7 support for people experiencing emotional crises. You can call the lifeline at 1-800-273-8255, or go on their website to live chat. [https://suicidepreventionlifeline.org/](https://suicidepreventionlifeline.org/)

Please do not hesitate to call Sarah Kirkpatrick, LCSW, LCAS with Mission Children’s Specialists at 828-213-1869 if you have any trouble setting up services.

**Haywood County**

If you have North Carolina Medicaid and would like to set up an intake for mental health/behavioral health services, you can do so by calling Vaya Health (previously called Smoky Mountain Center) at 1-800-849-6127.

A customer service representative will connect you with a provider who accepts Medicaid and can offer services to your child based on their situation.

If you are willing to travel outside of Haywood County let the Vaya Health Representative know, as there may be more options outside of the county.

Typically, an assessment will be done first to determine the level of care that your child will need. Then, they will have an appointment with the clinician who will be working with them regularly.

If you have a preference for a specific provider, you may also call them directly to set up intake. Many providers have walk-in hours for the initial assessment.

For Haywood County, providers who see children include:

Appalachian Community Services- 828-837-0071

Meridian Behavioral Health Services- 828-564-1923

*There may be other individual practitioners in Haywood County for outpatient therapy only - please ask Vaya Health about this if you are interested.*
If there is a behavioral or mental health crisis before you establish care with a provider, please call Mobile Crisis at 888-573-1006. There is no charge for this service.

You may also receive walk-in crisis services at RHA’s C3-356 located at 356 Biltmore Ave, Asheville, NC 28801 24 hours per day.

If you or your child is in immediate danger, is having a medical emergency, or is threatening themselves or others please call 9-1-1. **

The Lifeline- 24/7 support for people experiencing emotional crises. You can call the lifeline at 1-800-273-8255, or go on their website to live chat. https://suicidepreventionlifeline.org/

Please do not hesitate to call Sarah Kirkpatrick, LCSW, LCAS with Mission Children’s Specialists at 828-213-1869 if you have any trouble setting up services.

Henderson County

If you have North Carolina Medicaid or NC Health Choice and would like to set up an intake for mental health/behavioral health services, you can do so by calling Vaya Health (previously called Smoky Mountain Center) at 1-800-849-6127.

A customer service representative will connect you with a provider who accepts Medicaid and can offer services to your child based on their situation.

If you are willing to travel outside of Henderson County let the Vaya Health Representative know, as there may be more options outside of the county.

Typically, an assessment will be done first to determine the level of care that your child will need. Then, they will have an appointment with the clinician who will be working with them regularly.

If you have a preference for a specific provider, you may also call them directly to set up intake. Many providers have walk-in hours for the initial assessment.

For Henderson County, the comprehensive provider who sees children is:

Family Preservation Services- 828-697-4187
Mountain Counseling Agency- 828-692-7300
There may be other individual practitioners in Haywood County for outpatient therapy only—please ask Vaya Health about this if you are interested.

**If there is a behavioral or mental health crisis before you establish care with a provider, please call Mobile Crisis at 888-573-1006. There is no charge for this service.**

If you or your child is in immediate danger, is having a medical emergency, or is threatening themselves or others please call 9-1-1. **

The Lifeline- 24/7 support for people experiencing emotional crises. You can call the lifeline at 1-800-273-8255, or go on their website to live chat. [https://suicidepreventionlifeline.org/](https://suicidepreventionlifeline.org/)

Please do not hesitate to call Sarah Kirkpatrick, LCSW, LCAS with Mission Children’s Specialists at 828-213-1869 if you have any trouble setting up services.

**Jackson County**

If you have NC Medicaid or NC Health Choice and would like to set up an intake for mental health/behavioral health services, you can do so by calling Vaya Health (previously called Smoky Mountain Center) at 1-800-849-6127.

A customer service representative will connect you with a provider who accepts Medicaid and can offer services to your child based on their situation.

Typically, an assessment will be done first to determine the level of care that your child will need. Then, they will have an appointment with the clinician who will be working with them regularly.

If you have a preference for a specific provider, you may also call them directly to set up intake. Many providers have walk-in hours for the initial assessment.

For Jackson County, the comprehensive providers who see children are:

Meridian Behavioral Health Services  
P.O. Box 2187  
154 Medical Park Loop  
Sylva, NC 28779-5271  
828-631-3973  

Christine Mercier, Compassionate Counseling Services (Ages 16+) – 828-269-3168
There may be other individual practitioners in Jackson County for outpatient therapy only—please ask Vaya Health about this if you are interested.

**If there is a behavioral or mental health crisis before you establish care with a provider, please call Mobile Crisis at 888-573-1006. There is no charge for this service.

If you or your child is in immediate danger, is having a medical emergency, or is threatening themselves or others please call 9-1-1. **

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Please do not hesitate to call Sarah Kirkpatrick, LCSW, LCAS with Mission Children’s Specialists at 828-213-1869 if you have any trouble setting up services.

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**Madison County**

If you have North Carolina Medicaid or NC Health Choice and would like to set up an intake for mental health/behavioral health services, you can do so by calling Vaya Health at 1-800-849-6127.

A customer service representative will connect you with a provider who accepts Medicaid and can offer services to your child based on their situation.

If you are willing to travel outside of Madison County let the Vaya Health Representative know, as there may be more options outside of the county.

Typically, an assessment will be done first to determine the level of care that your child will need. Then, they will have an appointment with the clinician who will be working with them regularly.

If you have a preference for a specific provider, you may also call them directly to set up intake. RHA does have walk-in hours for the initial assessment.

For Madison County, the comprehensive provider who sees children is:

RHA Health Services- 828-232-6845

There may be other individual practitioners in Madison County for outpatient therapy only—please ask Vaya Health about this if you are interested.
If there is a behavioral or mental health crisis before you establish care with a provider, please call Mobile Crisis at 888-573-1006. There is no charge for this service.

If you or your child is in immediate danger, is having a medical emergency, or is threatening themselves or others please call 9-1-1. **

The Lifeline- 24/7 support for people experiencing emotional crises. You can call the lifeline at 1-800-273-8255, or go on their website to live chat. https://suicidepreventionlifeline.org/

Please do not hesitate to call Sarah Kirkpatrick, LCSW, LCAS with Mission Children’s Specialists at 828-213-1869 if you have any trouble setting up services.

Macon County

If you have North Carolina Medicaid or NC Health Choice and would like to set up an intake for mental health/behavioral health services, you can do so by calling Vaya Health at 1-800-849-6127.

A customer service representative will connect you with a provider who accepts Medicaid and can offer services to your child based on their situation.

If you are willing to travel outside of Macon County let the Vaya Health Representative know, as there may be more options outside of the county.

Typically, an assessment will be done first to determine the level of care that your child will need. Then, they will have an appointment with the clinician who will be working with them regularly.

If you have a preference for a specific provider, you may also call them directly to set up intake. Some agencies do have walk-in hours for the initial assessment.

For Macon County, comprehensive providers who see children are:

Appalachian Community Services-
100 Thomas Heights, Suite 206
Franklin, NC 28734
(828) 524-9385

Meridian Behavioral Health Services
102 Thomas Heights
Franklin, NC 28734
828-631-3973
There may be other individual practitioners in Macon County for outpatient therapy only—please ask Vaya Health about this if you are interested.

**If there is a behavioral or mental health crisis before you establish care with a provider, please call Mobile Crisis at 888-573-1006. There is no charge for this service.**

If you or your child is in immediate danger, is having a medical emergency, or is threatening themselves or others please call 9-1-1. **

The Lifeline- 24/7 support for people experiencing emotional crises. You can call the lifeline at 1-800-273-8255, or go on their website to live chat. https://suicidepreventionlifeline.org/

Please do not hesitate to call Sarah Kirkpatrick, LCSW, LCAS with Mission Children’s Specialists at 828-213-1869 if you have any trouble setting up services.

**McDowell County**

If you have North Carolina Medicaid or NC Health Choice and would like to set up an intake for mental health/behavioral health services, you can do so by calling Vaya Health (previously called Smoky Mountain Center), at 1-800-849-6127.

A customer service representative will connect you with a provider who accepts Medicaid and can offer services to your child based on their situation.

If you are willing to travel outside of McDowell County let the Vaya Health Representative know, as there may be more options outside of the county.

Typically, an assessment will be done first to determine the level of care that your child will need. Then, they will have an appointment with the clinician who will be working with them regularly.

If you have a preference for a specific provider, you may also call them directly to set up intake. RHA does have walk-in hours for the initial assessment.

**McDowell County Providers-**

A Caring Alternative- 828-437-3000
Multiple locations

FOCUS Behavioral Health Services- 828-439-8191
2533 Airport Rd, Marion, NC

RHA Health Services- 828-232-6845
There may be other individual practitioners in Haywood County for outpatient therapy only-
please ask Vaya Health about this if you are interested.

**If there is a behavioral or mental health crisis before you establish care with a provider,
please call Mobile Crisis at 888-573-1006. There is no charge for this service.

If you or your child is in immediate danger, is having a medical emergency, or is threatening
themselves or others please call 9-1-1.**

The Lifeline- 24/7 support for people experiencing emotional crises. You can call the lifeline at
1-800-273-8255, or go on their website to live chat. [https://suicidepreventionlifeline.org/](https://suicidepreventionlifeline.org/)

Please do not hesitate to call Sarah Kirkpatrick, LCSW, LCAS with Mission Children’s Specialists
at 828-213-1869 if you have any trouble setting up services.

**Mitchell County**

If you have North Carolina Medicaid and would like to set up an intake for mental
health/behavioral health services, you can do so by calling Vaya Health at 1-800-849-6127.

A customer service representative will connect you with a provider who accepts Medicaid and
can offer services to your child based on their situation.

If you are willing to travel outside of Mitchell County let the Vaya Health Representative know,
as there may be more options outside of the county.

Typically, an assessment will be done first to determine the level of care that your child will
need. Then, they will have an appointment with the clinician who will be working with them
regularly.

If you have a preference for a specific provider, you may also call them directly to set up intake.

The Comprehensive Provider in Mitchell County is:

**RHA Health Services Inc**

129 Skyview Circle

Spruce Pine, NC 28777

Phone : 828-232-6844
There may be other individual practitioners in Mitchell County for outpatient therapy only- please ask Vaya Health about this if you are interested.

**If there is a behavioral or mental health crisis before you establish care with a provider, please call Mobile Crisis at 888-573-1006. There is no charge for this service.**

If you or your child is in immediate danger, is having a medical emergency, or is threatening themselves or others please call 9-1-1. **

The Lifeline- 24/7 support for people experiencing emotional crises. You can call the lifeline at 1-800-273-8255, or go on their website to live chat. https://suicidepreventionlifeline.org/

Please do not hesitate to call Sarah Kirkpatrick, LCSW, LCAS with Mission Children’s Specialists at 828-213-1869 if you have any trouble setting up services.

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**Rutherford County**

If you have Medicaid and would like to set up an intake for mental health/behavioral health services, you can do so by calling Vaya Health at 1-800-849-6127.

A customer service representative will connect you with a provider who accepts Medicaid and can offer services to your child based on their situation.

If you are willing to travel outside of Rutherford County let the Vaya Health Representative know, as there may be more options outside of the county.

Typically, an assessment will be done first to determine the level of care that your child will need. Then, they will have an appointment with the clinician who will be working with them regularly.

If you have a preference for a specific provider, you may also call them directly to set up intake. Family Preservation Services does have walk-in hours for the initial assessment.

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Rutherford County Providers-

Family Preservation Services (range of behavioral health services)-704-344-0491

Karen Loftis- 828-748-5765 (individual/family counseling only)

Charlotte Whitaker- 828-382-0171 (individual/family counseling only)
**If there is a behavioral or mental health crisis before you establish care with a provider, please call Mobile Crisis at 888-573-1006. There is no charge for this service.**

*If you or your child is in immediate danger, is having a medical emergency, or is threatening themselves or others please call 9-1-1. **

The Lifeline- 24/7 support for people experiencing emotional crises. You can call the lifeline at 1-800-273-8255, or go on their website to live chat. [https://suicidepreventionlifeline.org/](https://suicidepreventionlifeline.org/)

Please do not hesitate to call Sarah Kirkpatrick, LCSW, LCAS with Mission Children’s Specialists at 828-213-1869 if you have any trouble setting up services.

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**Swain County**

If you have North Carolina Medicaid and would like to set up an intake for mental health/behavioral health services, you can do so by calling Vaya Health at 1-800-849-6127.

A customer service representative will connect you with a provider who accepts Medicaid and can offer services to your child based on their situation.

If you are willing to travel outside of Swain County let the Vaya Health Representative know, as there may be more options outside of the county.

Typically, an assessment will be done first to determine the level of care that your child will need. Then, they will have an appointment with the clinician who will be working with them regularly.

If you have a preference for a specific provider, you may also call them directly to set up intake. Many providers have walk-in hours for the initial assessment.

For Swain County, the comprehensive provider who sees children are:

Appalachian Community Services- 828-837-0071

*There may be other individual practitioners in Swain County for outpatient therapy only- please ask Vaya Health about this if you are interested.*

**If there is a behavioral or mental health crisis before you establish care with a provider, please call Mobile Crisis at 888-573-1006. There is no charge for this service.**
If you or your child is in immediate danger, is having a medical emergency, or is threatening themselves or others please call 9-1-1. **

The Lifeline- 24/7 support for people experiencing emotional crises. You can call the lifeline at 1-800-273-8255, or go on their website to live chat. https://suicidepreventionlifeline.org/

Please do not hesitate to call Sarah Kirkpatrick, LCSW, LCAS with Mission Children’s Specialists at 828-213-1869 if you have any trouble setting up services.

**Transylvania County**

If you have North Carolina Medicaid and would like to set up an intake for mental health/behavioral health services, you can do so by calling Vaya Health at 1-800-849-6127.

A customer service representative will connect you with a provider who accepts Medicaid and can offer services to your child based on their situation.

If you are willing to travel outside of Transylvania County let the Vaya Health Representative know, as there may be more options outside of the county.

Typically, an assessment will be done first to determine the level of care that your child will need. Then, they will have an appointment with the clinician who will be working with them regularly.

If you have a preference for a specific provider, you may also call them directly to set up intake. Many providers have walk-in hours for the initial assessment.

For Transylvania County, the comprehensive providers who see children are:

Meridian Behavioral Health- 828-564-1923

*There may be other individual practitioners in Swain County for outpatient therapy only- please ask Vaya Health about this if you are interested.*

**If there is a behavioral or mental health crisis before you establish care with a provider, please call Mobile Crisis at 888-573-1006. There is no charge for this service.

If you or your child is in immediate danger, is having a medical emergency, or is threatening themselves or others please call 9-1-1. **
The Lifeline- 24/7 support for people experiencing emotional crises. You can call the lifeline at 1-800-273-8255, or go on their website to live chat. [https://suicidepreventionlifeline.org/](https://suicidepreventionlifeline.org/)

Please do not hesitate to call Sarah Kirkpatrick, LCSW, LCAS with Mission Children’s Specialists at 828-213-1869 if you have any trouble setting up services.

**Other Counties**

If you have NC Medicaid and live in the following counties, you may schedule an intake for mental health/behavioral health services by calling Partners Behavioral Health Management Office at 1-888-235-HOPE (4673). **Burke**

- Catawba
- Cleveland
- Gaston
- Iredell
- Lincoln
- Surry
- Yadkin

A customer service representative will connect you with a provider who accepts your insurance and can offer services to your child based on their situation.

Typically, an assessment will be done first to determine the level of care that your child will need. Then, they will have an appointment with the clinician who will be working with them regularly.

If you have a preference for a specific provider, you may also call them directly to set up intake. Many providers have walk-in hours for the initial assessment.

**If there is a behavioral or mental health crisis before you establish care with a provider, please call mobile crisis at 888-573-1006. There is no charge for this service.**

**If you or your child is in immediate danger, is having a medical emergency, or is threatening themselves or others please call 9-1-1. **

The Lifeline- 24/7 support for people experiencing emotional crises. You can call the lifeline at 1-800-273-8255, or go on their website to live chat. [https://suicidepreventionlifeline.org/](https://suicidepreventionlifeline.org/)
Please do not hesitate to call Sarah Kirkpatrick, LCSW, LCAS with Mission Children’s Specialists at 828-213-1869 if you have any trouble setting up services.

**Setting Up Therapy with Private Insurance**

If you have private insurance or North Carolina Health Choice and would like to see a therapist, you can call the customer service number on the back of your insurance card. You will need to request a list of mental health providers who are in network with your insurance company and you can choose a provider from that list.

You may also find a provider on the website psychologytoday.com. You can search for a therapist or psychiatrist, and can specify criteria including type of insurance they accept, specialty area, and location.

If you are insured, but cannot afford your copay or deductible, Open Path Collective may be an option for you. Open Path Collective is a program that helps under-insured people access therapy. Membership is a one time $49 fee, and this gets you access to a whole network of therapists and psychologists who have agreed to see Open Path members for 30-50$ per session. Their website: [www.openpathcollective.org](http://www.openpathcollective.org)

**If there is a behavioral or mental health crisis before you establish care with a provider, please call Mobile Crisis at 888-573-1006. There is no charge for this service.**

You may also receive walk-in crisis services at RHA’s C3-356 located at 356 Biltmore Ave, Asheville, NC 28801 24 hours per day.

**If you or your child is in immediate danger, is having a medical emergency, or is threatening themselves or others please call 9-1-1. **

The Lifeline- 24/7 support for people experiencing emotional crises. You can call the lifeline at 1-800-273-8255, or go on their website to live chat. [https://suicidepreventionlifeline.org/](https://suicidepreventionlifeline.org/)

Please do not hesitate to call Sarah Kirkpatrick, LCSW, LCAS with Mission Children’s Specialists at 828-213-1869 if you have any trouble setting up services.
ALPHA-ADRENERGICS

Name of medication: Clonidine, Kapvay (Clonidine – ER), Guanfacine (Tenex), Intuniv (Guanfacine – ER)

Medication class: Alpha 2 adrenergic agonist anti-hypertensives, not CNS stimulants

FDA approval: Kapvay and Intuniv approved for treatment of ADHD in children 6-17 years. Clonidine and guanfacine have been used off-label in children with ADHD, tic disorders and sleep onset problems for decades.

Onset of Effect: Short-acting clonidine and guanfacine may have onset within 1-2 hours. Extended-release onset (Kapvay and Intuniv) onset is around 4-8 hours.

Duration of action: variable, and limited information available. For most children, clonidine 4-6 hours, Kapvay around 6-12 hours
Guanfacine (Tenex) around 6-8 hours, Intuniv 8-15 hours

Dosing
Initial dose <6 years, clonidine 0.1 mg tablets, ¼-1/2 tablet, guanfacine 1 mg tablets, ¼ to ½ tablet
6+ years, clonidine 0.1 tab, ½-1 tablet, guanfacine ½ - 1 tablet
Kapvay 1 tablet (0.1 mg) QHS, increasing to 1 tablet BID
Intuniv 1 tablet (1 mg) QAM

Dose adjustments: Usually increase every 3-7 days to avoid side effects. Clonidine may be given QHS only for sleep, or TID for ADHD. Kapvay is given BID, usual dose range 0.2-0.4 mg daily. Guanfacine is usually given BID or TID for ADHD. Intuniv is usually given as single dose in AM, although may be given QHS or BID, usual dose range 1-4 mg/day. Dose should not be stopped abruptly as this may cause rebound hypertension

Monitoring therapeutic response: Monitor blood pressure and heart rate. There is no routine blood monitoring.


Black Box warning: None

Most common adverse reactions:
Hypotension, somnolence, fatigue, nausea, lethargy, irritability.

Clinical pearls: Clonidine and guanfacine are frequently used to target impulsivity, hyperactivity, and aggression. Care must be taken in increasing the dose slowly, as well as avoiding rapid reduction or discontinuation due to the possibility of rebound hypertension.
ANXIOLYTICS

Names of Medications commonly used in treatment of anxiety disorders: Atarax or Vistaril (hydroxyzine), Ativan (lorazepam), Buspar (buspirone), Cymbalta (duloxetine), Klonopin (clonazepam), Valium (diazepam). Also SSRIs, Effexor (venlafaxine) and atypicals may be helpful in some children.

Medication classes: NSRI (Cymbalta); SSRI (Celexa, Lexapro, Luvox, Prozac, Zoloft); Benzodiazepines (Ativan, Klonopin, Valium); Antihistamine (hydroxyzine); Buspirone (Buspar) mechanism unknown

FDA approval for: Cymbalta approved for treatment of generalized anxiety disorder in children 7 and older. Luvox (fluvoxamine), Prozac (fluoxetine) and Zoloft (sertraline) approved for treatment of OCD. Other meds are used off-label.

Dosing:

Hydroxyzine – start with 10 mg BID/TID

Ativan – 0.25 mg to titrate cautiously to maximum of 0.05 mg/kg q4-8h; Max: 2 mg/dose

Buspar – start with 5 mg bid and titrate to as much as 20-30 mg bid

Cymbalta – start 15 mg daily, increase after 2 weeks to 15 mg BID, and titrate up to 30 mg BID

Klonopin – start 0.25 mg daily or PRN, titrate up cautiously to a maximum of 0.1 to 0.3 mg/kg given in two to three divided doses.

Valium – start 1 mg two to four times a day with a maximum of 2.5 mg two to four times a day.

Prozac – start with 5 mg once a day. Can gradually increase to 30 mg a day.

Zoloft – 10-12.5 mg once a day to gradually increase to maximum of 150 mg a day

Luvox – 12.5 mg – 25 qhs. Can gradually increase to a maximum of 200 mg in patients under 11 years and to 300 mg in patients above 11. Above 50 mg, divide bid.

How supplied:

Hydroxyzine – 10 mg/5 ml liquid, 10, 25 and 50 mg tablets

Ativan – 0.5, 1 and 2 mg tablets

Buspar – 5, 7.5, 10, 15 and 30 mg

Cymbalta – 20, 30 and 60 mg delayed release capsules

Klonopin – 0.125, 0.25, 0.5, 1 and 2 mg tablets; 1 mg disintegrating tablet

Valium – 2, 5 and 10 mg tablets

Prozac – 10 mg tablets and capsules, 20 and 40 mg tablets and capsules and 20 mg/5 ml oral solution

Zoloft – 25, 50 and 100 mg tablets, 20 mg/ml oral solution

Luvox- 25, 50, 100 mg tablets and 100 and 150 mg extended release capsules
**Most Common Side Effect:** Antihistamine and Benzodiazepine: Drowsiness, sedation

Buspar may cause dizziness, headache, nausea and light-headedness, but generally well tolerated

Cymbalta and Effexor may cause nausea, dry mouth, sweating, constipation, dizziness, or sleep problems

**Black Box warning:** None

**Precautions:** Dependency on benzodiazepines. May use with caution for short periods

**Clinical Pearls:** Child and family therapy usually leads to significant improvement in anxiety disorders in children. There are powerful placebo effects in the treatment of anxiety, so the effectiveness of these medications over placebo in clinical trials has been hard to establish.
ATOMOXETINE (STRATTERA)

Name of medication: Strattera (Atomoxetine)

Medication class: Non-selective norepinehrine reuptake inhibitor, not a CNS stimulant

FDA approved for: ADHD, ages 6-18 years.

Onset of effect: 1-2 weeks for initial effect, 4-6 weeks for full affect.

Initial dose: Up to 70 kg body weight: 0.5 mg/kg/day in the morning or in 2 divided doses. More than 70 kg body weight: 40 mg/day in the morning or in 2 divided doses. Can be taken with or without food. Caustic - do not open capsule.

Target dose is 1.4 mg/kg/day. May be better tolerated if given BID.

Dose Adjustments:

<table>
<thead>
<tr>
<th>Pt Weight Range</th>
<th>Starting Dose (3 days min)</th>
<th>Target Daily Dose</th>
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<tbody>
<tr>
<td>40-62 lbs</td>
<td>18 mg</td>
<td>25 mg</td>
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<tr>
<td>63-93 lbs</td>
<td>25 mg</td>
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</tr>
<tr>
<td>94-126 lbs</td>
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<td>60 mg</td>
</tr>
<tr>
<td>127 + lbs</td>
<td>40 mg</td>
<td>80 mg</td>
</tr>
</tbody>
</table>

Monitoring therapeutic response: Monitor blood pressure, heart rate, height, and weight. There is no routine blood monitoring.

Safety monitoring: Contraindications

- Jaundice from liver injury
- Hypersensitivity to atomoxetine or other constituents of the product
- Atomoxetine use soon after discontinuing an MAOI
- Narrow angle glaucoma
- Pheochromocytoma or history of pheochromocytoma
- Severe cardiovascular disorders (may cause clinically important increases in heart rate or blood pressure)

Black Box warning:

- Monitor for suicidal ideation, clinical worsening, and unusual changes in behavior (1 in 250).

Most common adverse reactions:

Nausea, vomiting, fatigue, decreased appetite, abdominal pain, somnolence, tachycardia

Less common occurrences: Possible allergic reactions, aggressive behavior, priapism.
**Clinical pearls:** Atomoxetine is usually well tolerated, especially if given BID. It may be less effective than stimulant medications in children who are hyperactive. Does not affect tics. Frequently considered in comorbid anxiety, especially in children with ADHD inattentive type. Slow start up time to maximum effect is a drawback. Capsule must be swallowed whole. Dose can be discontinued without tapering.

**ATYPICALS (ATYPICAL ANTI PSYCHOTICS) - ABILIFY**

**Name of Medication:** Aripiprazole (Abilify)

**Medication class:** Atypical antipsychotics

**FDA approval for:** Treatment of the irritability associated with Autism for individuals 6 and above. Also indicated for treatment of schizophrenia in those 13 and above, treatment of Bipolar I in those 10 and above and treatment of children 6 and above with Tourette’s Disorder.

**Dosing:** Initiate treatment with 1-2 mg once a day. In children it can help with sleep if given at night. In children the dose can be increase to a maximum of 15 mg. Adolescents may need doses as high as 20 mg. The dose should be increased slowly to avoid certain side effects.

**How supplied:** Oral solution-1 mg/ml, Tablets-2, 5, 10, 15, 20 & 30 mg; Decimelts 10 & 15 mg

**Most Common Side Effect:** Increased appetite and weight gain. But less likely than risperidone

**Uncommon side effects:** Elevated serum lipids and/or serum glucose

**Occasional side effects:** Abnormal movements of the face, eyes and/or mouth (extrapyramidal side effects). Treatment is to give Benadryl or hydroxyzine and decrease dose; Akathisia – an uncomfortable or “wormy” feeling in the legs. Children may say their legs hurt. Decrease dose.

**Rare side effects:** Malignant neuroleptic syndrome – high fever and muscle stiffness; needs immediate emergency care; Tardive Dyskinesia – abnormal movement of the shoulders and mouth which occur only after prolonged use.

**Black Box warning:** Increased suicidality risk in children, adolescents, and young adults w/ major depressive or other psychiatric disorders; weigh risk vs. benefit; depression and certain other psychiatric disorders themselves assoc. w/ incr. suicide risk; observe all pts for clinical worsening, suicidality, or unusual behavior changes; advise families and caregivers of need for close observation and communication w/ prescriber; not approved for depression in peds pts

**Precautions:** May lower the seizure threshold; use cautiously in individuals with seizures. Doses should be lowered by half if taken with Prozac, Paxil or Wellbutrin. Higher dose may be needed if taken with Tegretal, Trileptal or Topamax

**Clinical Pearls – Atypicals:** All of these medications have some potential for weight gain. All need lab monitoring. All carry a small risk of causing movement disorders. The concern about breast enlargement has received much publicity, but is not usually a problem in low doses.

**Risperidone** appears to be highly effective for irritability and aggression in children with autism, but is associated with increased appetite and weight gain. **Abilify** is less likely to cause weight gain and is not associated with increased prolactin and breast enlargement. **Geodon** (ziprasidone) may cause QT
prolongation. Seroquel (quetiapine) is relatively sedating. Zyprexa (olanzapine) is sedating and is likely to cause excessive weight gain. Geodon, Seroquel and Zyprexa are not approved for treatment of irritability in children with autism.

**ATYPICALS (ATYPICAL ANTIPSYCHOTICS) - Risperdal**

**Name of Medication:** Risperidone (Risperdal)

**Medication class:** Atypical antipsychotics

**FDA approval for:** treatment of schizophrenia in individuals 13 and older, for treatment of bipolar disorder in individuals 10 and older and for treatment of irritability associated with Autism in children 5 to 16 years.

**Dosing:** Initiate treatment with 0.25 mg once or twice a day. The dose is gradually increased based on response. Maximum total daily dose 3-6 mg.

**How supplied:** Oral solution-1 mg/ml, Tablets 0.25, 0.5, 1, 2, 3 mg; M-Tabs 0.5, 1, 2 mg

**Most Common Side Effect:** Increased appetite and weight gain

**Uncommon side effects:** Elevated serum prolactin which may cause breast development in boys or lactation in girls

**Occasional side effects:** Abnormal movements of the face, eyes and/or mouth (extrapyramidal side effects). Treatment is to give Benadryl or hydroxyzine and decrease dose; Akathisia – an uncomfortable or “wormy” feeling in the legs. Children may say their legs hurt. Decrease dose.

Elevated serum lipids and/or serum glucose

**Rare side effects:** Malignant neuroleptic syndrome – high fever and muscle stiffness; needs immediate emergency care; Tardive Dyskinesia – abnormal movement of the shoulders and mouth which occur only after prolonged use.

**Black Box warning:** None for pediatric patients

**Precautions:** May lower the seizure threshold; use cautiously in individuals with seizures.

**Clinical Pearls – Atypicals:** All of these medications have some potential for weight gain. All need lab monitoring. All carry a small risk of causing movement disorders. The concern about breast enlargement has received much publicity, but is not usually a problem in low doses.

Risperidone appears to be highly effective for irritability and aggression in children with autism, but is associated with increased appetite and weight gain. Abilify is less likely to cause weight gain and is not associated with increased prolactin and breast enlargement. Geodon (ziprasidone) may cause QT prolongation. Seroquel (quetiapine) is relatively sedating. Zyprexa (olanzapine) is sedating and is likely to cause excessive weight gain. Geodon, Seroquel and Zyprexa are not approved for treatment of irritability in children with autism.
MOOD STABILIZERS/ANTI-EPILEPTICS

Names of Medications: Lamictal (lamotrigine), Tegretol (carbamazepine), Trileptal (oxcarbazepine) and Depakote (divalproex, valproate), Topamax (topiramate)

Indications: Several medications which are most commonly used to treat seizures are also approved for treatment of several psychiatric disorders in adults. Lamictal is approved for treatment of bipolar I. Depakote is used to treat a variety of seizure disorders and manic episodes in bipolar disorder. Trileptal has not been approved for treatment of mood disorders; however, due to its low side-effect profile and case reports of a mood stabilizing effect, it is sometimes used for mood stability. Topamax enhances CNS inhibitory neurotransmitter GABA and may have mood stabilizing effects (while suppressing appetite or preventing weight gain), but has not been approved for this indication.

Dosing: Dosing for mood stability can follow same schedule as dosing to treat seizures.

Lamictal – tablets 25 mg, 100 mg, 150 mg, 200 mg. Start 25 mg, then BID, then increase by 25 mg q 2 week to max of 3-4 mg/kg/day to max of 100 mg BID

Tegretol - ER CAP: 100 mg, 200 mg, 300 mg; TAB: 200 mg; ER TAB: 100 mg, 200 mg, 400 mg; CHEWABLE: 100 mg; SUSP: 100 mg per 5 mL. Start 100 mg ER PO bid, incr. by 100 mg/day qwk; Max: 1000 mg/day ER; Info: screen pts of Asian ancestry for HLA-B*1502 allele before initiating tx; adjust dose based on tx response and serum levels; do not cut/crush/chew ER tab; taper dose gradually to D/C

Trileptal - TAB: 150 mg, 300 mg, 600 mg; SUSP: 300 mg per 5 mL. Start: 8-10 mg/kg/day PO divided bid, incr. dose over 2-4wk; Max: 60 mg/kg/day; Info: consider screening pts of Asian ancestry (see pkg insert) for HLA-B*1502 allele before initiating tx; taper dose gradually to D/C

Depakote - TAB: 125 mg, 250 mg, 500 mg. Start: 10-15 mg/kg/day PO divided bid-tid, incr. by 5-10 mg/kg/day q7 days; Max: 60 mg/kg/day divided bid-tid; Info: adjust dose based on tx response and serum levels; divide doses >250 mg/day; give w/ food; taper dose gradually to D/C

Topamax - SPRINKLE CAP: 15 mg, 25 mg; TAB: 25 mg, 50 mg, 100 mg, 200 mg. Start: 25 mg PO qhs x1wk, then incr. by 25-50 mg/day qwk; Max: 250 mg/day; Info: taper dose gradually to D/C

How supplied: Lamictal comes in a variety of tablet sizes and in chewable, oral dissolvable tablets and extended release. Depakote or Depakene comes a tablets, liquid, sprinkles and extended release forms. Trileptal comes as a liquid and in tablet form.

Side Effects: Lamictal has been associated with severe allergic reactions including Stevens-Johnson Syndrome. It the dose is increased very slowly, this is a rare side effect. Trileptal and Tegretol allergic rashes, headaches and nausea; rarely low serum sodium. Depakote can cause an elevation in liver function tests and a decrease in blood counts. Blood work needs to be monitored. It can also cause polycystic ovary disease in pubertal females. Depakote has also been associated with weight gain. Topamax may cause fatigue, dizziness, numbness, weight loss
Precautions: Risk of Stevens-Johnson severe rashes in patients of Asian ancestry, recommend avoiding or obtaining pharmacogenomic testing

SSRI ANTIDEPRESSANTS

Name of Medication: Zoloft (sertraline), Prozac (fluoxetine), Celexa (citalopram), Lexapro (escitalopram), Luvox (fluvoxamine), Cymbalta (duloxetine)

Medication class: Selective serotonin reuptake inhibitors (SSRIs) – antidepressant medications

FDA approval: Some antidepressants are FDA approved for the treatment of childhood enuresis, major depression (MDD), generalized anxiety disorder and OCD in children and adolescents; however, not all antidepressants are FDA approved for use in pediatric patients.

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- **childhood enuresis**
- **MDD**
- **OCD**

Onset of effect: Highly variable, from a few days to a few weeks

Dosing initial dose: Typical starting doses: sertraline 12.5-25 mg, fluoxetine 5-10 mg, citalopram 5-10 mg, escitalopram 5 mg, fluvoxamine 25-50 mg, duloxetine 15-30 mg.

Dose adjustments: Because of slow onset of effect, dose increases usually made slowly, every 2-4 weeks. Some medications may be administered in divided doses BID to minimize side effects.

Monitoring therapeutic response: Monitor clinical response and emergence of side effects.

Safety monitoring: Warnings and precautions: Seizure disorders, Cardiac conduction abnormalities

Common side effects: GI side effects, including nausea, vomiting, diarrhea. Weight gain, sexual dysfunction in adults>children. Less commonly, behavioral activation (restlessness, agitation, insomnia), serotonin syndrome

Black Box warning: Suicidality and Antidepressant Drugs
In the FDA review, no completed suicides occurred among nearly 2,200 children treated with SSRI medications. However, about 4 percent of depressed adolescents taking SSRI medications experienced suicidal thinking or behavior, including actual suicide attempts—twice the rate of those taking placebo pills.
Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior.

Clinical pearls: If no response to an SSRI, consider pharmacogenomics testing to help guide treatment, e.g., “OneOme”.
**STIMULANTS**

**Name of Medication:** Most commonly used stimulants are methylphenidate (such as brand names Ritalin, Concerta, Metadate, Focalin, Quillivant, Quillichew, Aptensio, Daytrana) - and amphetamine salts (Adderall, Vyvanse, Dexedrine, Dyanavel, Evekeo, Zenzedi, Adzenys).

**Medication class:** CNS stimulants

**FDA approval for:** treatment of ADHD in children ages 6 and older.

**Onset of effect:** 30-60 minutes.

**Dosing:** Varies according to specific medication. Long-acting stimulants may last 8-12 hours. Most children can manage well on a single dose in the morning. Some may need medicine twice a day, and some do best by combining long- and short-acting stimulants. Stimulants may be taken 7 days a week and there is no medical need to stop medications during vacations.

**Doses adjustments:** Usually start low and titrate up every 1-2 weeks to optimal dose. Fewer side effects if taken with food. Concerta needs to be swallowed whole. Other tablets whole or crushed. Capsules can be opened and sprinkled. Liquid and chewable preparations available. Daytrana is patch applied in morning and taken off 3 hours before bed-time. Monitoring therapeutic response: Stimulants are very effective in decreasing hyperactivity and impulsivity, and also increasing the ability to keep attention focused. May also help to decrease oppositional and defiant behavior. Clinic visits and rating scales are used to help check your child’s progress. We rely on observations and reports from parents, teachers, and child. Your child will need to be followed either in our clinic or by the primary care doctor, with initial follow-up within 1 month, and then additional follow-up visits every 2-4 months during the first year.

**Safety monitoring:**

Stimulant medications are very safe and have been in use for more than 60 years. They are not addictive or habit forming. Children do not become dependent on them and they do not lead to drug or alcohol abuse. We monitor blood pressure, heart rate, height, and weight. There is no routine blood monitoring necessary.

Abuse and misuse of stimulant medications can be a problem in teens and adults.

Contraindications may include Congenital heart disease, tic disorders/Tourette syndrome

**Black Box warning:** Potential for dependency and drug abuse in individuals with history of drug abuse

**Most common adverse reactions:**

Short-term side effects - loss of appetite, irritability, headaches, stomach aches and sleep problems - are seen in about 30% percent of children who begin stimulants, but these are generally mild and often disappear after a few days of treatment. Side effects are more likely in younger children, at higher doses, and if the stimulant is taken on an empty stomach. Loss of appetite may lead to weight loss.
Some children – fewer than 10% - feel sad, nervous, or agitated. About 15-20% have irritability and difficult behavior in the late afternoon or evening when the dose is wearing off. This is called rebound effect. Fewer than 5% of children begin to have tics, such as eye blinking or throat clearing. Stimulants may bring out these tics in children who are already having them or who are prone to develop them. In high doses, there is occasionally a slow-down in growth but this returns to normal when the medication is stopped. Stimulants may increase heart rate and blood pressure and should not be used in children with significant heart disease without approval from the child’s cardiologist.

**Clinical pearls:** We may try one methylphenidate and one of the amphetamine stimulants to see which may be more effective for a particular child.
Best Practices for Medication Management for Children, Adults and Seniors with Intellectual and Developmental Disabilities

May 2018

MEDICAL HEALTH HOMES
Promoting Integrated, Person-Centered Care for People with Intellectual & Developmental Disabilities
Children and adults with intellectual and developmental disabilities have higher rates of medical problems and unmet health needs and are treated with psychiatric medications at high rates. About 30-40% of people with intellectual and developmental disabilities (I/DD) meet criteria for a psychiatric disorder or have severe challenging behaviors such as self-injury or aggression. People with I/DD experience the full range of psychiatric disorders, including anxiety, depression, bipolar disorder, schizophrenia and post-traumatic stress disorder. The most common psychiatric disorders are anxiety and depression in adults and anxiety and ADHD in children.

There is growing concern about the extensive use of anti-psychotic medications, increased use of multi-drug regimens and a significant increase in psychoactive medication use in the treatment of individuals with I/DD. Though children and adults with I/DD often have complex symptoms and multiple medical conditions there is limited evidence that multi-drug regimens is best practice. Taking multiple medications increases the likelihood of drug interactions and other adverse effects. The use of complex multi-drug regimens may cause a cascade of problems in patients with I/DD who have fragile neurological and physical health.

This document is intended to inform clinicians of best practice recommendations and resources regarding the use of psychotherapeutic medications for the treatment of children, adults and seniors with intellectual and developmental disabilities. It is also intended to offer some basic information about the North Carolina disability service system. It is not intended to establish rigid standards of treatment but to assist in prescribing and monitoring the pharmacotherapy of the patient with an intellectual or developmental disability.
This document was developed by Community Care of North Carolina (CCNC) and the Medication Work group of the Medical Health Homes for People with I/DD initiative, a project funded by the North Carolina Council on Developmental Disabilities and a partnership of The Arc of NC, Easter Seals UCP NC and Autism Society of NC. A list of work group members can be found on page 31.

Comments or questions about this document may be directed to:

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Disability and Health Consultant
Project Director, IDD Medical Health Home Initiative

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Disclaimer

These Guidelines are based on the current state of knowledge on effective and appropriate care, at the time of publication. These Guidelines may not apply to all patients; therefore, each guideline should be tailored to the individual patient, based on clinical judgment. Proper use, adaption, modifications or decisions to disregard these or other guidelines in whole or part, are entirely the responsibility of the clinician who uses these Guidelines. The authors bear no responsibility for the use of these Guidelines by third parties.
EXPERT JUDGMENT RATHER THAN MECHANICAL RULES

SHARED DECISION-MAKING AND OPEN COMMUNICATION WITH THE PATIENT, FAMILY AND HEALTHCARE TEAM

GO LOW, GO SLOW WHEN BEGINNING, INCREASING OR DECREASING PSYCHOTROPIC MEDICATIONS

EXPECTATION OF HOPE

ATTENTION TO THE UNIQUE ASSETS AND NEEDS OF THE INDIVIDUAL AND FAMILY

STRONG CLINICIAN-PATIENT RELATIONSHIP

ATTENTION TO THE UNIQUE ASSETS AND NEEDS OF THE INDIVIDUAL AND FAMILY

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EXPERT JUDGMENT RATHER THAN MECHANICAL RULES

SHARED DECISION-MAKING AND OPEN COMMUNICATION WITH THE PATIENT, FAMILY AND HEALTHCARE TEAM
People with intellectual and developmental disabilities have different and perhaps limited ways to communicate their distress and pain. Many people with I/DD are referred for psychiatric care due to “problem” behaviors. When considering the use of medications or other interventions to address challenging behaviors, an appropriate evaluation should address the following issues:

**A) Medical/Physiologic** drivers of the behavior including, but not limited to, possible physical illness, sources of pain/discomfort, medication side effects. *(see Common Medical Issues)*;

**B) The presence of (or lack of) contributing psychiatric co-morbidities** including but not limited to mood disorders, anxiety disorders, psychotic disorders, and substance abuse/dependence disorders;

**C) Psychosocial/Environmental factors** including but not limited to assessment of the appropriateness of current environments, functional behavioral analysis, communication needs, and exposures to common modifiable stressors (e.g., sensory stressors, changes in routines/care providers);

**D) Abuse and Trauma:** Children and adults with I/DD are four to ten times more likely to be abused than the general population. People with DD tend to be abused more frequently, for longer periods of time, are more likely to be abused by a caregiver or someone they know, and are more likely to remain in abusive situations. Signs of abuse may include sleep

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**CONSUMER STORY:**

**COMPREHENSIVE ASSESSMENT OR REASSESSMENT OF CHALLENGING BEHAVIORS IN THE CONTEXT OF /DD**

**Jose** is a 42 y/o male with ASD, bipolar disorder, and seizures. There is a family history of diabetes and hypertension. His brother reports that sometimes Jose has “behaviors” but it is difficult to identify a specific cause. Following a recent “aggressive episode” late at night Jose was evaluated in the local Emergency Department where he was prescribed clozapine, which can contribute to constipation. After several weeks his brother saw no improvement. During a regularly scheduled appointment with the neurologist, the family reported Jose had been complaining of dry mouth, stomach pain, and constipation. The neurologist referred Jose to a renal specialist, who ordered an ultrasound that revealed massive constipation. The renal specialist prescribed bowel medication and encouraged adequate fluid intake.

**These interventions resolved the physical complaints and “behaviors”**.

At the return appointment with the neurologist the clozapine was discontinued as it may actually have intensified Jose’s behaviors and physical symptoms.
problems, changes in eating habits, depression, anxiety, self-injurious behaviors, and suicide attempts.

This comprehensive assessment is most commonly accomplished through standard practice which should include collaboration between the primary medical provider/prescriber of psychiatric medication and other key non-medical providers (e.g., family, caregivers, educators, therapists).

Comprehensive assessment or reassessment may occasionally demand specialized consultation from medical subspecialists, I/DD behavioral specialists (e.g., psychologists, behavior analysts), Allied Health Professionals (e.g. speech/language pathologists, occupational therapists, physical therapists), or educational specialists. Lack of access to specialized consultation should not serve as a barrier to standard/routine ongoing comprehensive assessment/reassessment.

**Common Medical Issues** that can cause irritability, altered mental status and externalizing behavior problems and may mimic acute mental illness are reviewed in section five (pages 9 and 10).

A comprehensive assessment can include multiple sources of information and activities, including:

<table>
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<tr>
<th>COMPREHENSIVE ASSESSMENT COMPONENTS</th>
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<tr>
<td>Detailed record review</td>
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<td>Psychiatric interview</td>
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<td>Informant interviews</td>
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<td>Team collaboration</td>
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<td>Symptom surveys</td>
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<td>Input from other professionals, such as nursing, occupational therapy, physical therapy, direct support professionals</td>
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<td>If possible, pre-appointment home visit and/or conference call</td>
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<td>Detailed report</td>
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<td>Direct patient examination</td>
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<td>Follow-up review of the evaluation with family.</td>
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<td>Office physical and neurological exam</td>
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</table>
Each person with I/DD has a unique profile of strengths and challenges that impact their communication, including behaviors.

Challenging Behavior may be defined as “culturally abnormal behavior of a significant intensity, frequency or duration that physical safety of the person or others is placed at risk or is likely to significantly limit a person’s ability to be part of their community”. (Brown, Brown and Dibiasio, 2013)

Generally, these behaviors have occurred more than once and often have been happening repeatedly.

Challenging behaviors and many behaviors of concern are influenced by:

- **biological** (pain, illness, medication side effects, sensory sensitivities, challenges to executive functions and self-regulation (working memory, mental flexibility, and self-control), physical disabilities

- **social** (challenges to communication, boredom, lack of social opportunities, challenges to social awareness, inconsistent approaches of caregivers, lack of training for caregivers, caregivers failing to provide for person’s wishes and needs)

- **environmental** (exposure to impoverished environments or ones experienced as aversive (i.e. due to noise and lighting), limited choices/control, or limited access to preferred objects or activities)

  psychological (lack of meaningful engagement, difficulty coping with stress and change, limited skills for exercising control over one’s own life, feeling excluded, lonely, devalued, labelled, disempowered, living up to people’s negative expectations)

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**CONSUMER STORY: BEHAVIOR CHANGES, CHALLENGES AND SUPPORTS**

**Jada** is a 63-year-old female, with moderate ID, seizure disorder and a history of UTIs. She lives with her mother who is 84-years old. Ms. Brown’s medical chart is extensive and documents that she has been seen by numerous health care professionals and had several in-patient hospitalizations, resulting in complicated medication regimes. Her mother reports recent behavior changes including crying, interrupted sleep, falls, and disorientation. Jada is presently taking two (2) antipsychotics. The family physician thinks a comprehensive evaluation is needed and has requested a psychiatric referral to evaluate her medications, possible dementia, and family support needs.
Comprehensive assessment considering the above factors will inform more effective treatment, which frequently needs to include multiple modalities (i.e. Speech and Language interventions, counseling, Applied Behavior Analysis (ABA) based interventions, and medications). Behavior change is most effective when we teach people what they can do to be safe and healthy and how to meet their needs rather than focusing on what they should not do. For example, a student with I/DD who assaults his teacher to gain escape from an academic task he finds difficult might be taught to change this “target behavior” by learning to ask for help or ask for a break.

Adaptive functioning can be described as how well a person meets what is expected in terms of personal independence and responsibility compared to others of similar age. It includes conceptual, social, and practical skills that all people learn in order to function in their daily lives. Adaptive behavior delays and deficits are part of the Intellectual Disability definition and are used to determine the level of severity.

CONSUMER STORY:
COMMON MEDICAL ISSUES THAT CAN CAUSE IRRITABILITY, ALTERED MENTAL STATUS AND EXTERNALIZING BEHAVIOR PROBLEMS AND MAY MIMIC ACUTE MENTAL ILLNESS

**Thomas** is an 11-year-old male with Down syndrome. Recently he has shown an increase in agitated behaviors, increased appetite and occasional gagging after meals. Ongoing attempts to address his agitation resulted in the use of multiple high dose antipsychotics. However, medication interventions coupled with a change in his daily activities were ineffective. A review of Thomas’ medical history indicated that GI issues might be a problem. A referral for a GI evaluation revealed significant esophageal effects from GERD that had likely been present for some time. Thomas was also significantly constipated. By treating Thomas’ medical problems there was a marked decrease in his agitated behaviors. His mother describes him as a “new person”.

<table>
<thead>
<tr>
<th>Common Medical Issues</th>
<th>Clinical Features and Detection</th>
<th>Medications that may contribute or cause the symptom</th>
<th>Other risk factors that may contribute to or cause the symptom</th>
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<tbody>
<tr>
<td><strong>Constipation</strong></td>
<td>Often missed on physical exam. Best detected through detailed bowel monitoring and charting, or KUB (abdominal x-ray) with request for specific comment on stool content. Risk of repeat incidents is high</td>
<td>Benztropine</td>
<td>Cerebral Palsy; Down Syndrome; Williams syndrome; Autism</td>
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<td>Other anticholinergic drugs</td>
<td>Not enough movement, fluid, fiber</td>
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<td>Opioid analgesics</td>
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<td>Antipsychotic medications</td>
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<td>Diuretics</td>
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<td>Iron supplements</td>
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<td><strong>Gastro-Esophageal Reflux</strong></td>
<td>May be under-appreciated by informants. May notice burping, gagging or coughing when eating; complaints of sore throat or increased challenging behaviors or agitation around meals. Sometimes staff report “intentional vomiting.” Other indications can include: Increased hand mouthing; pica; agitation and restlessness in the middle of the night; &amp; unplanned weight loss regardless of intake.</td>
<td>Fosamax</td>
<td>Cerebral Palsy, Cornelia de Lange syndrome; Autism</td>
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<td>Oral corticosteroids</td>
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<td><strong>Sedation or Fatigue</strong></td>
<td>Person may become irritable and “refuse” activities due to fatigue and may even become aggressive when prompted. Also decreases ability to respond to non-medical interventions. May see reversal of sleep-wake cycle.</td>
<td>Benzodiazepines, hydroxyzine, diphenhydramine (sedation/lethargy), Beta blockers (fatigue/lethargy)</td>
<td>Down Syndrome at increased risk due to hypothyroidism, hypotonia and dementia</td>
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<td>Antipsychotics; PKU</td>
<td>Children with Autism Spectrum Disorder at heightened risk for sedation</td>
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</table>
Infections (UTIs, URIs, Otitis, Skin.)

Infections are sometimes missed and can be very uncomfortable, then driving challenges behaviors. Infections can worsen existing movement disorders or cause a delirium if persistent.

Extra-Pyramidal Side-effects (EPS) dystonias, akathisia

Muscle stiffness (dystonias) may be painful. Akathisia (intensive motor restlessness) is often misinterpreted as “mania.” Note that manic over activity is often excessive but goal directed while akathisia looks like the person is “jumping out of their skin” and cannot control urges to move.

Metoclopramide, first and second generation antipsychotics

Smith-Magenis Syndrome at increased risk due to impaired T-cell function

Williams syndrome at up risk for UTI due to renal anomalies

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<thead>
<tr>
<th>Common Medical Issues</th>
<th>Clinical Features and Detection</th>
<th>Medications that may contribute or cause the symptom</th>
<th>Other risk factors that may contribute to or cause the symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Problems</td>
<td>Dental pain can cause distress and fuel challenging behaviors. Individuals may need special help to tolerate dental procedures including sedation dentistry.</td>
<td>Anticholinergics (dry mouth)</td>
<td>Prader-Willi syndrome at increased risk due to thick viscous saliva</td>
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<td>Antiepileptic medications</td>
<td>Fragile X syndrome due to high arched palate</td>
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<tr>
<td>Sleep Problems</td>
<td>Sleep problems and disorders such as sleep apnea may be caused by or worsened by medications. Some IDD syndromes confer risk for sleep problems including difficulty initiating or maintaining sleep.</td>
<td>Some antidepressants, steroids</td>
<td>Trauma, abuse, lack of activities or structure, daytime sleeping</td>
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<td>Pseudoephedrine</td>
<td>Angelman, Cornelia de Lange &amp; Fetal Alcohol syndromes-common sleep problems</td>
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<td>Psychostimulants</td>
<td>Down Syndrome: high risk of obstructive sleep apnea</td>
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<td>Prader-Willi: high risk of sleep disorder due to weight</td>
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<td></td>
<td>Autism &amp; Tuberous Sclerosis increased risk of sleep disorder</td>
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<tr>
<td>Confusion, delirium, encephalopathy</td>
<td>Medications can cause altered mental states that can be mistaken for “psychosis” such as when the person says things that sound odd or unusual. These states are also seen with transient skill loss or memory problems, “waxing and waning” level of alertness and purposeless repetitive behaviors.</td>
<td>Glyburide/glimepiride, Valproic acid/divalproex, CNS polypharmacy</td>
<td>Delirium often associated with infection, especially in older population and people with cognitive impairment. Rapid drug changes, discontinuation syndromes. Vision &amp; hearing problems can result in substantial changes in behavior.</td>
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<tr>
<td>Headaches, Dizziness</td>
<td>Many medications cause headaches or even orthostasis (a drop in blood pressure on rising from a prone or seated position). Person may suddenly sit on the floor or may refuse activities, but may not be able to reliably describe these symptoms to others.</td>
<td>Beta blockers, trazodone, tricyclic antidepressants, Antiepileptic medications</td>
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<tr>
<td>Excessive food drive or dehydration</td>
<td>People with IDD may not control their own fluid intake and may become mildly dehydrated without caregivers noticing. Observe for dry skin, cracked lips, and monitor to insure adequate intake. Some medications increase appetite and then the person has challenging behaviors related to seeking food or liquids.</td>
<td>Lithium (caution with dehydration), mirtazapine, second generation antipsychotics, first generation antihistamines</td>
<td>Prader-Willi Syndrome</td>
</tr>
</tbody>
</table>
Life transitions: are important opportunities to review current medications, side effects, and health changes. It is also a chance to ensure that individuals, families and community providers are educated about current medications.
It is important to realize that not every person with I/DD receives formal disability services. In many cases the individual with I/DD may be reliant on themselves or family to monitor and report medication side effects, obtain refills, and raise drug related questions with their healthcare provider. Patient education and support is critical.

**PRIMARY CARE PROVIDER AND PHARMACIST:**

ASK if the person with a developmental disability is receiving formal disability services. If no, and the person is in need of services:

- Individuals can apply for NC Medicaid online at the North Carolina’s Department of Health and Human Services website: [https://medicaid-help.org/Primary-Information](https://medicaid-help.org/Primary-Information)
- Individuals can apply in person at their local Department of Social Services (DSS) office: [https://dma.ncdhhs.gov/medicaid/get-started](https://dma.ncdhhs.gov/medicaid/get-started)
- Contact the Call Center of the regional LME MCO to discuss eligibility, service options and community resources. To find more information on which LME MCO is linked to an individual’s county of residence [http://www.ncdhhs.gov/providers/lme-mco-directory](http://www.ncdhhs.gov/providers/lme-mco-directory)
- The medication review process can help reduce medication errors that are especially common among individuals who have complex health care needs and interact with multiple healthcare providers.

**CONSUMER STORY: THE IMPORTANCE OF LIFE TRANSITIONS**

**Sally** is a 23 y/o female with mild ID and a history of anxiety. Several months ago Sally moved from her family home to a group residential setting. Staff report that when Sally gets anxious she refuses to drink fluids and says “my heart hurts”. During a recent conversation Sally was tearful and stated she misses her boyfriend. During a weekend family visit her sister noted that “Sally is not herself, she did not want to do anything, it was hard to wake her up and she was quiet most of the weekend”. An appointment with her primary care provider revealed that Sally had low blood pressure and was dehydrated. Treatment focused on rehydration and adequate nutrition. However, the following week Sally again appeared lethargic, at times agitated and tearful, and complained “my heart is wrong”. The primary care provider suggested that Sally be monitored for hydration AND be evaluated for depression given her recent life transitions, including the loss of her boyfriend. Sally may benefit from individual or group therapy and medications.
- Develop a complete and accurate and current list of ALL medications an individual is taking (including non-prescription and alternative medications) including name, dosage, frequency, and route
- Compare this list with their medical record and to the list of medications obtained from the individual with IDD, family, disability provider and healthcare facility
- Review an up-to-date list of their prescribed medications at every appointment

Medication errors occur frequently when individuals are prescribed new medications or when they are admitted to or discharged from health care facilities.

**KEY TIMES OF LIFE TRANSITION:**
- School entry and exit: 0-4 year; 5-12 years; 14-18/21 years
- Residential/home changes: move away from family, move into new residence, new roommate
- Family changes: death of a caregiver; primary care giver now unable to provide care and a residential move is necessary
- Puberty can be a challenging time for a person with DD
- Age transitions: people with Down Syndrome may experience dementia at an earlier age and thus require medication review
- “Unexplained” or atypical behavior changes: crying, sleep, agitation, pain
- Annual individual support plan/person centered plan meeting for those receiving formal disability services: care coordinator should do a preliminary review of medications and request follow-up review if red flags are noted
- Annual Individual Education Plan meeting with the school system

**Disability system:** The primary point of contact varies, based on age, service needs, and community resources. Pages 21 – 23 provide additional information on the NC Disability Service System.
“Red Flag” Medication Review Guidelines for Individuals with Intellectual and Development Disabilities

**Purpose**: To assist Prescribers and Pharmacists, with the identification of “Red Flag” criteria which may be potentially harmful to an individual with I/DD while reviewing their medications.

“Red Flag” criteria indicate a need to review the individual’s clinical status in order to verify the medication regimen is accurate and appropriate. These parameters do not necessarily indicate that treatment is inappropriate, but they do indicate a need for further review.

For an individual with I/DD being prescribed a psychotropic medication, any of the following suggests the need for additional review of that individual’s clinical status:

**All Children, Adolescents, Adults, and Older Adults with I/DD**

1. **Absence of a thorough current and comprehensive assessment**
   (medical/physiologic drivers, psychiatric co-morbidities, psychosocial/environmental factors - see page 5 for detailed information) in the medical record at least every 6 months for children, at least every 1 year for adults, and at every transition point in a person’s life (see life transitions section on page 11).

   - YES
   - NO

2. **The prescribed psychotropic medication is not consistent with the evidenced-based principles of care** (see page 4 for Guiding Principles) for treating individuals with I/DD.

   - YES
   - NO

3. **Psychotropic polypharmacy (2 or more medications)** for a given mental disorder is prescribed before utilizing psychotropic mono-therapy (single medication).

   - YES
   - NO

4. **The psychotropic medication dose exceeds usual recommended doses*** (FDA and/or literature based maximum dosages – see Resources section for literature on medication dosages).

   - YES
   - NO

5. **The Prescriber (Primary Care Provider, Pediatrician, Psychiatrist, or Other Advanced Practice Provider) is not familiar with treating the I/DD population, and is not working in collaboration or consultation with a Prescriber who is comfortable treating the I/DD population.**

   - YES
   - NO

6. **Psychotropic medication therapy for longer than 6 months without re-evaluation** of the need for the medication.

   - YES
   - NO

7. **Psychotropic medication(s) prescribed without collaborating** with those who best know the individual with I/DD (family, caregivers) and those who provide long-term services and supports for each individual with I/DD.

   - YES
   - NO

8. **Prescribing psychotropic medication without a comprehensive treatment plan** that includes nonpharmacological interventions and other supports.

   - YES
   - NO
9: Prescribing of:

- Two (2) or more concomitant stimulants *1, or
- Two (2) or more concomitant alpha agonists 2, or
- Two (2) or more concomitant antidepressants 3, or
- Two (2) or more concomitant antipsychotics 4, or
- Two (2) or more concomitant mood stabilizers 5, excluding those diagnosed with a seizure disorder

* The prescription of a long-acting stimulant and an immediate release stimulant of the same chemical entity (e.g., methylphenidate) does not constitute concomitant prescribing.

Note: When switching psychotropic medications, medication overlaps (where one medication overlaps with another medication for a period of time) and cross taper (slowly decreasing the dose of one medication while slowly increasing the dose of another medication) should occur in a timely fashion, generally within 12 weeks.

Children and Adolescents with I/DD (0-20)

1: Four (4) or more psychotropic medications prescribed at the same time (medications being prescribed to deal with the side effects of the primary medication are not included in this count (i.e., benztropine, diphenhydramine, trihexyphenidyl)).

2: Psychotropic medications are prescribed for children of very young age, including children receiving the following medications with an age of:

- Stimulants 1: Less than three (3) years of age
- Alpha Agonists 2: Less than four (4) years of age
- Antidepressants 3: Less than four (4) years of age
- Antipsychotics 4: Less than four (4) years of age
- Mood Stabilizers 5: Less than five (5) years of age

Note: Kids with I/DD of very young age are very susceptible to the behavioral side effects of these medications.

3: Prescribing of chronic benzodiazepine 6 medication(s) excluding children prescribed rectal diazepam (Diastat®) for seizure disorders.

4: Antipsychotic medication(s) prescribed continuously without appropriate monitoring of glucose and lipids at least every 6 months.

Adults with I/DD (Age 21-54)

1: Four (4) or more psychotropic medications prescribed at the same time (medications being prescribed to deal with the side effects of the primary medication are not included in this count (i.e., benztropine, diphenhydramine, trihexyphenidyl)).

2: Antipsychotic medication(s) prescribed continuously without appropriate monitoring of glucose and cardiovascular risk at least every 1 year.
Older Adults with I/DD (55 and older)

1: Three (3) or more psychotropic medications prescribed at the same time (medications being prescribed to deal with the side effects of the primary medication are not included in this count (i.e., benztropine, diphenhydramine, trihexyphenidyl).

☐ YES  ☐ NO

2: At least one (1) psychotropic medication and individual with I/DD has a history of repeated falls.

☐ YES  ☐ NO

3: Individual with I/DD is having an acute change in cognition from baseline and is prescribed one at least (1) medication that can harm an older adult's cognition:

- Antihistamines/anticholinergic medicines 7  ☐ YES
- Anti-anxiety (benzodiazepines 6) and antidepressant medicines 3  ☐ NO
- Sleep aids 8
- Antipsychotics 4

1 Examples of stimulants include methylphenidate, (Ritalin®, Concerta®), dexamphetamine (Focalin®), lisdexamfetamine (Vyvanse®), and amphetamine mixed salts (Adderall®).

2 Examples of alpha agonists include Guanfacine ER (Intuniv®) and clonidine ER (Kapvay®).

3 Examples of antidepressants include Escitalopram (Lexapro®), Sertraline (Zoloft®), fluoxetine (Prozac®), and Trazodone.

4 Examples of antipsychotics include Risperidone (Risperdal®), olanzapine (Zyprexa®), Aripiprazole (Abilify®), and Quetiapine (Seroquel®).

5 Examples of mood stabilizers include Divalproex (Depakote®), lithium, Lamotrigine (Lamictal®), and carbamazepine (Tegretol®, Equetro®).

6 Examples of benzodiazepines include lorazepam (Ativan®), diazepam (Valium®), alprazolam (Xanax®) and temazepam (Restoril®).

7 Examples of antihistamines/anticholinergic medications include benztropine (Cogentin®), diphenhydramine (Benadryl®), and trihexyphenidyl.

8 Examples of sleep aids include zolpidem (Ambien®), zaleplon (Sonata®), and eszopiclone (Lunesta®).

This resource was adapted from the Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care - 5th Version (March 2016) that was developed by the Texas Department of Family and Protective Services and The University of Texas at Austin College of Pharmacy. Any changes, and additional criteria were decided upon by the I/DD Medication Management Workgroup.
Community Pharmacy Enhanced Services Network
A Different Kind of Pharmacy for Patients Who Need a Higher Level of Care

CPESN pharmacies bring a new dimension to the delivery of healthcare. Community pharmacists have unrivalled access to the complex patients that are your biggest challenge.

CPESN North Carolina pharmacists see their complex patients on average 35 times per year. These same patients see their primary care physician only about 3.5 times per year. Every one of these interactions is an opportunity to get more value from medications and alert physicians when new issues arise that could lead to readmission or a worsening of the patient’s condition.

What is “enhanced” about CPESN North Carolina pharmacies?

Services
CPESN pharmacies provide specialized services key to managing complex patients, such as medication reconciliation, non-English-labeling, adherence coaching, daily dose multi-medication blister packaging, 24-hour emergency service, and home delivery/home visits.

Relationship to the care team
Our pharmacists work hand-in-hand with primary care physicians, care managers, and behavioral health providers, sharing information, improving compliance, and contributing to a shared, patient-centered care plan.

Relationship with the patient
Community pharmacists know their local complex patients well, and enjoy a high degree of patient trust. This can open doors to non-compliant patients who aren’t doing well but are reluctant to accept additional help. CPESN pharmacies are focused on interventions that change patient behavior and lead to improved outcome.
How can CPESN North Carolina pharmacies help you?

Reduce readmissions by identifying problems complex patients in time to make changes in literacy or treatment or medications.

Boost value by removing barriers to better with medication adherence, such as low health cognitive impairment.

Improve patient satisfaction – 98 percent of patients closely utilizing a CPESN pharmacy felt their care was your coordinated among multiple providers.

Improve budget predictability by working with complex patients to get more value from pharmaceutical spend.

Improve Care and Maximize Your

CPESN delivers more attention, more more resources to complex patients in an effective, sustainable way that improves and lowers

For more information about CPESN contact:

Troy Trygstad, Pharm.D, M.B.A.,
Vice President of Provider Pharmacy
ttrygstad@cpe

*Participating CPESN

The Pharmacy Locator can help you find an "enhanced" pharmacy in your area.  https://www.cpesn.com

https://www.cpesn.com
24-hour Emergency Service/On Call – Dispensing – medication dispensing services offered after the normal business hours in urgent situations or special circumstances

24-hour Emergency Service/On Call – Non-Dispensing – non-medication dispensing services offered after the normal business hours such as DTP resolution or medication reconciliation in urgent situations or special circumstances

Adherence Packaging – unit dose packaging designed to assist patients with medication organization by incorporating date and time into the unit dose device

Clozapine Dispensing and Monitoring – ability to dispense clozapine via registration with registry and ongoing lab monitoring for patients

Collection of Vital Signs – ability to collect heart rate, respiration rate, temperature and blood pressure in your pharmacy for patients

Compounding, Non-Sterile – art and science of creating personalized, non-sterile medications

Compounding, Sterile – art and science of creating personalized, sterile medications

Comprehensive Medication Review – a review of patient medications, including prescription, over-the-counter, herbal medications and dietary supplements to identify, resolve, and prevent medication-related problems, including adverse events

DME Billing – Medicare and Medicaid – ability to bill both Medicare and Medicaid for durable medical equipment

Home Delivery – pharmacy-provided delivery service, regardless of cost to patient

Home Visits – act of sending a pharmacist or other qualified pharmacy staff member into a patient’s home to complete a medication reconciliation/review or other medication-related service

Immunizations – Non-Medicaid – administration of vaccines in the pharmacy as authorized by protocol

In Depth Counseling/Coaching – additional counseling offered in the pharmacy, requiring a pharmacist or qualified staff member to step out of traditional pharmacy workflow in order to complete the activity
**Long-Acting Injections** – ability to administer injections for long-acting medications in your pharmacy; may require employment of non-pharmacy professional staff (nurse, etc.)

**Med Synchronization Program** – aligning all patient medications to be filled at the same time each month

**Multi-Lingual Staff** – employees a pharmacy staff member who can fluently speak languages other than English or has a contracted service with a vendor who can translate between the pharmacist/pharmacy representative and the patient or patient representative.

**Naloxone dispensing** – ability and willingness to dispense naloxone and deliver proper counseling for its use in narcotic overdose situations

**Nutritional Counseling** – delivery of education to help patients develop balanced diets that may also be tailored to individual chronic conditions

**Personal Medication Record** – ability to create a comprehensive list of current patient medications manually or from dispensing software

**Care Plan Development/Reinforcement** – document detailing patient information pertinent to helping a patient reach a particular healthcare goal

**Point of Care Testing** – ability to perform medical testing and deliver results in the pharmacy (HbA1c, cholesterol, blood glucose, etc.)

**Pre-filling Syringes for Oral Administration** – ability to fill individual-dosed oral syringes before medication is dispensed

**Presumptive Eligible (Medicaid) Medication Dispensing** – willingness to dispense medication based on “good faith” belief that the patient is eligible for Medicaid and is in the application process to be billed to Medicaid once actual eligibility is obtained

**Smoking Cessation Program** – educational program offered in your pharmacy designed to assist patients who desire to stop smoking

**Specialty Pharmacy Dispensing** – ability to dispense medications deemed “specialty drugs” based on the fact that they require specialized due to cost, treatment of a rare condition, requirement of special handling, use of a limited distribution network, or requirement of ongoing clinical assessment

**Standardized Assessments** – ability and willingness to administer questionnaire-based surveys to patients (i.e. pain assessment, PHQ-9, etc.)

**Long-term Care Chart Reviews** – evaluate medical charts for patients in residential care facilities such as nursing homes
Disease state management programs – educational programs offered in your pharmacy to enhance patient knowledge about chronic diseases (anticoagulation, cardiology, COPD/asthma, diabetes, hyperlipidemia, etc.)
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why are you planning to add this medication?</td>
<td></td>
</tr>
<tr>
<td>What should we expect as a result of this addition?</td>
<td></td>
</tr>
<tr>
<td>How long will it take for this medicine to work? How long will the individual be on it?</td>
<td></td>
</tr>
<tr>
<td>What common side effects might we see?</td>
<td></td>
</tr>
<tr>
<td>What red flags should we contact you about?</td>
<td></td>
</tr>
<tr>
<td>Is the medication addictive? Can it be abused?</td>
<td></td>
</tr>
<tr>
<td>Will labs need to be drawn before or while the individual is on this medication?</td>
<td></td>
</tr>
<tr>
<td>Does this medication interact with any over-the-counter medications, food, activities, or with any of the individual's other medications?</td>
<td></td>
</tr>
<tr>
<td>Concerns if the individual becomes pregnant?</td>
<td></td>
</tr>
</tbody>
</table>
The state agencies that are ultimately responsible for the design of the state system are:

**Division of Mental Health, Developmental Disabilities and Substance Abuse Services (MHDDAS)**
- [http://www.ncdhhs.gov/divisions/mhddsas](http://www.ncdhhs.gov/divisions/mhddsas)

**Division of Medicaid Assistance (Medicaid)**
- [https://dma.ncdhhs.gov/](https://dma.ncdhhs.gov/)

**Local Management Entity (LME) Managed Care Organization (MCO)** manages the provider network, authorizes services, and provides care coordination in a “managed care model” for children and adults with MH, DD and SA. This includes the Innovations waiver and other behavioral health services and the registry of unmet needs in their catchment area.

To find more information on which LME/MCO is linked to a county of residence:
- [http://www.ncdhhs.gov/providers/lme-mco-directory](http://www.ncdhhs.gov/providers/lme-mco-directory)

**Community Alternatives Program for Children (CAP/C)** provides cost-effective home care for medically fragile children (through age 20) who would otherwise require long-term hospital care or nursing facility care.
- **DMA Clinical Policy and Programs CAP/C:**
  - 919-855-4340
  - [https://www2.ncdhhs.gov/DMA/services/capc.htm/](https://www2.ncdhhs.gov/DMA/services/capc.htm/)

**Community Alternatives Program for Disabled Adults (CAP/DA)** is a Medicaid program that makes care at home a real possibility for people who face nursing home placement. The CAP/DA program waives certain NC Medicaid requirements to furnish an array of home and community based services to **adults with disabilities 18 years of age and older** who are at risk of institutionalization.
- **DMA Clinical Policy and Programs:**
  - 919-855-4340
  - [https://www2.ncdhhs.gov/dma/services/capda.htm/](https://www2.ncdhhs.gov/dma/services/capda.htm/)
Early Periodic Screening Diagnosis Treatment (EPSDT): is a federal law that all medically necessary health care services are to be provided to Medicaid-eligible children under the age of 21. Services must be ordered by the child’s physician or another licensed clinician. Prior approval from the Division of Medical Assistance may be required to verify medical necessity for some services. Covered services must be medically necessary and include periodic screening services, vision, dental and hearing services, medical and adaptive equipment and other necessary health care such as occupational, physical, speech and language therapy.

- **Medical Assistance Operations Section:**
  919-855-4260
  [http://dma.ncdhhs.gov/providers/programs-services/medical/Health-Check-Early-and-Periodic-Screening-Diagnosis-and-Treatment](http://dma.ncdhhs.gov/providers/programs-services/medical/Health-Check-Early-and-Periodic-Screening-Diagnosis-and-Treatment)

Innovations Waiver: North Carolina resource for funding services and supports for people with ID/DDs who are at risk for institutional care. This waiver provides community-based services and supports to promote choice, control, and community membership. The local management entity/managed care organization (LME/MCO) receives a set amount of money (capitation) each year to help people get I/DD services. There are a limited number of Innovation Waiver slots available that are managed by the LME MCO.

- **To learn more about Innovation Waiver services, contact your LME MCO.**

Traumatic Brain Injury (TBI) waiver: is a pilot waiver designed to provide more comprehensive services for adults with a TBI which occurred on or after their 22nd birthday.

The catchment area is Cumberland, Durham, Johnston, and Wake counties.

- Contact the [Alliance LME MCO](https://www.alliancebhc.org/) and [NC DHHS Division of Medical Assistance](https://dma.ncdhhs.gov/) for additional information.

**B 3 services** are available statewide and are intended to expand supports for individuals with complex needs who are eligible for Medicaid. Services for children and adults with IDD include community guide/navigation, de-institutionalization service array, in-home skill building, respite, supported employment, psychiatric consultation. **NC Innovations Waiver participants are eligible only for b3 Psychiatric Consultation.**

- **Contact the local LME MCO for more information.**
Early Intervention/Infant Toddler Program: part of the N.C. Division of Public Health. The Infant-Toddler Program provides supports and services for families and their children, birth to three who have special needs. Sixteen Children’s Developmental Services Agencies (CDSAs) across North Carolina work with local service providers to help families help their children succeed. Services include: Service Coordination, physical, occupational and speech-language therapies, family support, special instruction, and assistive technology.

• Contact NC ITP
  919-707-5520
  or your local CDSA program
  http://www.beeearly.nc.gov/index.php/contact/cdsa

SERVICE PLANNING

Individualized Education Program (IEP) is a written document required for each child who is eligible to receive special education services. The IEP spells out the child’s learning needs, the services the school will provide and how progress will be measured. The IEP is the responsibility of the Local Education Agency.

Individual Support Plan (ISP) is the written details of the supports, activities, and resources that an individual, Personal Agent or Service Coordinator, and other people of the individual's choice agree are important to or for achieving and maintaining personal outcomes. The ISP is required for anyone receiving services through the Innovations Waiver.

Person-Centered Plan (PCP) is the umbrella under which all planning for treatment, services and supports occurs. The PCP focuses on the strengths, interests and needs of an individual. The PCP is required for anyone receiving state funded services.

Individual Family Support Plan (IFSP) is a written treatment plan that maps out the early intervention (EI) services a child will receive, as well as how and when these services will be administered. It details the child’s current levels of functioning, specific needs and goals for treatment. Local Children’s Developmental Services Agencies (CDSAs) are available to help families, caregivers, and professionals serve children with special needs through the Infant Toddler Program.

• Contact your local CDSA program
• http://www.beeearly.nc.gov/index.php/contact/cdsa
DIAGNOSIS

Developmental Disability (DD) means a disability that is manifested before the person reaches twenty-two (22) years of age, and

- is likely to continue indefinitely,
- results in substantial functional limitations,
- is attributable to intellectual disability or related conditions which include cerebral palsy, epilepsy, autism or other neurological conditions, and
- reflects the individual’s need for assistance that is lifelong or extended duration that is individually planned and coordinated.

DD INCLUDES:

- Intellectual Disability (ID)
- Autism Spectrum Disorder (ASD)
- Muscular Dystrophy
- Cerebral Palsy (CP)
- Fetal Alcohol Syndrome
- Traumatic Brain Injury (TBI)
- Down Syndrome
- Some other disorders (Prader-Willi, Fragile X)

INTELLECTUAL DISABILITY (ID)

- Intellectual disability is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills.
- Generally, an IQ score of around 70 or less indicates a limitation in intellectual functioning
- Adaptive behavior includes three skill types:
  - Conceptual skills—language and literacy; money, time, and number concepts; and self-direction
  - Social skills—interpersonal skills, social responsibility, self-esteem, gullibility, naïveté (i.e., wariness), social problem solving, and the ability to follow rules/obey laws and to avoid being victimized.
  - Practical skills—activities of daily living (personal care), occupational skills, healthcare, travel/transportation, schedules/routines, safety, use of money, use of the telephone.
MEDICATIONS AND RELATED TERMS

**Adverse Drug Event** - refers to any injury occurring at the time a drug is used, whether or not it is identified as a cause of the injury.

**Adverse Drug Reaction**: Adverse drug reactions are caused by adverse drug effects and are an unintended consequence resulting from medication use; with adverse drug reactions, the drug must be causally related to the symptoms manifested, occur at usual doses, and are caused by the pharmacologic action of the drug; onset may be sudden or develop over time.

**Akathisia**: distressful feeling of restlessness, inability to be still, often described as something moving inside the body

**Allergic Reaction**: Symptoms which occur when your body's immune system becomes sensitized to a substance in the medication or the drug itself, and perceives it as a foreign invader and releases chemicals to defend against it, leading to the symptoms of rash, hives, swelling, or difficulty breathing

**Alpha agonists**: medications trigger contraction of smooth muscle throughout the body. They are especially active in the blood vessels, particularly the arteries, and have a vasoconstrictive effect.

**Alpha blocker agents**: relax certain muscles and help small blood vessels remain open. They work by keeping the hormone norepinephrine (noradrenaline) from tightening the muscles in the walls of smaller arteries and veins, which causes the vessels to remain open and relaxed. This improves blood flow and lowers blood pressure. Examples include Minipress (prazosin), Cardura (doxazosin)

**Antianxiety Agents**: work to treat the symptoms of anxiety in various ways including affecting the neurotransmitter GABA (benzodiazepines) or promoting skeletal muscle relaxation by affecting histamine receptors (hydroxyzine). Examples include Benzodiazepines Valium, Xanax, Klonopin, Ativan

**Anticholinergic agents**: medications which inhibit parasympathetic activity by blocking the neurotransmitter acetylcholine; anticholinergics are used for asthma, COPD, diarrhea, nausea, vomiting, Parkinson's disease and to decrease smooth muscle spasms (e.g., in the urinary bladder). Examples are Cogentin, Artane, and Benadryl.

**Anticonvulsants**: also commonly known as antiepileptic drugs or AEDs, with uses that include, but are not limited to, treatment of seizures, mood disorders, migraines and neuropathic pain. They should be used carefully, with
consideration of medication interactions and potential side effects, especially for some individuals with IDD. Examples include Depakote, Lamictal, Tegretol, Neurontin

**Antidepressants**: affect neurotransmitters in the brain such as serotonin, norepinephrine and dopamine and can be used to treat depression, anxiety, eating disorders and pain. Examples include Celexa, Prozac, Effexor, Wellbutrin

**Antiepileptic drugs (AEDs)** (see Anticonvulsants described above) Depakote, Lamictal, Tegretol, Neurontin

**Antihistamines**: a group of medications that affect histamine receptors and are used for a wide variety of indications, including treatment of allergic reactions, insomnia, treatment of extrapyramidal side effects from antipsychotics, nausea, motion sickness and vertigo. Examples include Benadryl, Vistaril, Unisom

**Atypical Antipsychotic**: also known as the newer antipsychotics or second generation antipsychotics; have similar efficacy to older antipsychotics and their prominent side effects are more likely to include, but are not limited to, weight gain, diabetes, high cholesterol /blood lipids. Examples include Abilify, Seroquel, Zyprexa, Latuda, and others.

**Concomitant**: describes a situation when two or more medications are given at or almost the same time.

**Desired medication effects**: All medications have pharmacologic effects, those which are desired (i.e. the reason for treating a disease/using the medication) as well as those effects which are not desired (side effects or adverse effects)

**Diabetes**: a disease in which blood sugar levels are too high. Can result in damage to eyes, nerves, kidneys, heart disease, or stroke

- **Prediabetes**: blood sugar is higher than normal but not high enough to be called diabetes.
- **Hyperlipidemia**: the presence of too much cholesterol, which is a naturally occurring waxy, fat-like substance that the body needs. High levels of cholesterol in the blood can increase risk of heart disease.

**Drug allergy**: abnormal reaction of your immune system to a medication that can include, but is not limited to, hives, rash or fever, and less commonly trouble breathing.

**Drug interaction**: occurs when two or more drugs react with each other and may result in an unexpected side effect.

**Drug Levels**: lab measurements used to look for the presence and amount of a
medication in the blood.

**Drug sensitivity:** when the reaction to a medication is faster or there is a lower threshold to the effects of medications when compared to the response of others.

**Efficacy:** ability of a medication to achieve the desired effect.

**Extrapyramidal Symptoms / Side Effects (EPS):** there are four primary types of EPS

a) **Pseudoparkinsonism or Parkinsonian Syndrome:** these symptoms look like Parkinson’s Disease: tremor, shuffling gait, rigidity
   a. **Acute dystonic reaction:** bizarre, involuntary muscle spasms that can involve the head, face, back, arms or legs
   b. **Akathisia:** distressful feeling of restlessness, inability to be still, often described as something moving inside the body
   c. **Tardive Dyskinesia:** sucking or smacking of the lips, tongue thrust, purposeless movements in extremities; symptoms may take years to develop.

**Metabolic side effects/metabolic syndrome:** a group of conditions that increase risk for heart disease and diabetes, including high blood pressure, high blood sugar, high cholesterol and extra weight at the waist.

**Psychoactive/psychotropic medication:** medications that affect brain activities associated with mental process and behavior, including but not limited to antipsychotics, mood stimulators, ADHD meds, sleep aids, antidepressants, and antianxiety medications. Examples include Risperdal, Adderall, Ambien, Celexa, Klonopin

**Side Effects:** unwanted results of medication use.

**Stimulants:** used to stimulate the central nervous system by affecting the neurotransmitters norepinephrine and dopamine to treat ADHD, narcolepsy, depression, obstructive sleep apnea, shift-work disorder and obesity. Examples include Ritalin, Adderall, Vyvanse, Concerta

**Therapeutic Range:** a range of numbers given to use for evaluation of a specific number determined by lab test, sometimes for side effect evaluation or therapeutic efficacy.

**Typical Antipsychotic:** also known as the older antipsychotics or first generation agents; have similar efficacy to newer antipsychotics, side effects are more likely to include, but are not limited to, extrapyramidal symptoms and tardive dyskinesia. Examples include Haldol, Thorazine, Mellaril, and Prolixin
RESOURCES

American Academy of Developmental Medicine and Dentistry
  • www.aadmd.org

American Psychiatric Association Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia

Appropriate Use of Psychotropic Medications for People with IDD
Vanderbilt Kennedy Center
  • www.iddtoolkit.org

Autism Spectrum Disorder & Intellectual Disability Disorder: Psychotropic Medication Recommendations for Target Symptoms in Children and Adolescents
University of South Florida
  • http://www.medicaidmentalhealth.org/_assets/file/Guidelines/17-ASD%20&%20ID%20Guidelines%20(w%20references)%20%206.5%20x%209.5.pdf

Best Practices for Medication Management for Children & Adolescents in Foster Care
Community Care of North Carolina

Consensus guidelines for primary health care of adults with developmental disabilities, Canadian Consensus Guidelines
  • http://www.surreyplace.on.ca/documents/Primary%20Care/Primary%20Care%20of%20Adults%20with%20Developmental%20Disabilities%20Canadian%20Consensus%20Guidelines.pdf

Florida Best Practice Psychotherapeutic Medication Guidelines for Adult
University of South Florida
  • http://www.medicaidmentalhealth.org/_assets/file/Guidelines/Web_2015-Psychotherapeutic%20Medication%20Guidelines%20for%20Adults_Final_Approved1.pdf

Mental Health Medications
National institute of Mental Health
  • https://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml#part_149855

Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care
Texas Dept. of Family and Protective Services
  • https://www.dfps.state.tx.us/Child_Protection/Medical_Services/documents/reports/2016-03_Psychotropic_Medication_Utilization_Parameters_for_Foster_Children.pdf
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http://www.iddmedicalhealthhomencinitiative.com/

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of 2000.
MEDICATIONS: FREQUENTLY ASKED QUESTIONS AND DEFINITIONAL ISSUES

What is a narcotic?

Narcotic means a drug or other substance affecting mood or behavior and sold for nonmedical purposes, especially an illegal one.

Legally speaking, the term "narcotic" is imprecisely defined and typically has negative connotations. When used in a legal context in the U.S., a narcotic drug is one that is totally prohibited, such as heroin, or one that is used in violation of governmental regulation.

What is a controlled drug?

A controlled substance is generally a drug or chemical whose manufacture, possession, or use is regulated by a government, such as illicitly used drugs or prescription medications that are designated by law. ... The controlled substances do not include many prescription items such as antibiotics.

What is meant by Schedule II?

Drugs, substances, and certain chemicals used to make drugs are classified into five (5) distinct categories or schedules depending upon the drug’s acceptable medical use and the drug’s abuse or dependency potential. The abuse rate is a determinate factor in the scheduling of the drug; for example, Schedule I drugs have a high potential for abuse and the potential to create severe psychological and/or physical dependence. As the drug schedule changes-- Schedule II, Schedule III, etc., so does the abuse potential-- Schedule V drugs represents the least potential for abuse.

Schedule I drugs, substances, or chemicals are defined as drugs with no currently accepted medical use and a high potential for abuse. Some examples of Schedule I drugs are: heroin, LSD, marijuana (cannabis), 3,4-methylenedioxymethamphetamine (ecstasy), methaqualone, and peyote.

Schedule II drugs, substances, or chemicals are defined as drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence. Some examples of Schedule II drugs are: Vicodin, cocaine, methamphetamine, methadone, hydromorphone (Dilaudid), meperidine (Demerol), oxycodone (OxyContin), fentanyl, Dexedrine, Adderall, and Ritalin.

Schedule III drugs, substances, or chemicals are defined as drugs with a moderate to low potential for physical and psychological dependence. Schedule III drugs abuse potential is less than Schedule I and Schedule II drugs but more than Schedule IV. Some examples of Schedule III drugs are: Tylenol with codeine, ketamine, anabolic steroids, testosterone.

Schedule IV drugs, substances, or chemicals are defined as drugs with a low potential for abuse and low risk of dependence. Some examples of Schedule IV drugs are: Xanax, Soma, Darvon, Darvocet, Valium, Ativan, Talwin, Ambien, Tramadol.
Schedule V drugs, substances, or chemicals are defined as drugs with lower potential for abuse than Schedule IV and consist of preparations containing limited quantities of certain narcotics. Schedule V drugs are generally used for antidiarrheal, antitussive, and analgesic purposes. Some examples of Schedule V drugs are: cough preparations (Robitussin AC), Lomotil, Motofen, Lyrica

Are stimulant meds addictive?

Not usually addictive, although they are sometimes abused and misused, and may contribute to drug dependency in some individuals at risk for substance abuse. However, research has shown that children with ADHD - who may be at risk for substance abuse as adults - do not have a higher likelihood of substance abuse when their ADHD is treated with stimulants. In fact, the risk of substance abuse may be lower in those whose ADHD is successfully treated in childhood.

Do they stunt growth?

Stimulants can decrease appetite and cause problems with weight gain. In high doses there is a small risk of a small decrease in growth rate. That is why we monitor growth carefully to prevent growth suppression.

Will doses need to be continually increased to maintain effectiveness?

We start on low doses to avoid side effects and then increase the dose if needed. Some children may need higher doses with age and growth, but it is not due to tolerance or habituation. Many individuals respond well to low doses and continue to do well with low doses into the adolescent years.

How does the use of stimulants affect other disorders such as seizures, cardiac, and tic disorders?

Most neurologists and seizure specialists agree that stimulants can be used safely in children with seizure disorders. Since ADHD is common in children with epilepsy, the use of stimulants in such children is very common, and safety is supported by solid research evidence.

For children with tics or Tourette and ADHD, tics can increase in 1 out of 3 children when they start on a stimulant – but for 1 out of 3, the tics get better when the stimulant is started.

For children with complex heart disease, we will consult with the child’s cardiologist before starting stimulant medications. For normal (innocent) heart murmurs, this is not necessary.

Why do some children with ADHD take stimulants and other children take non-stimulant medications?

Stimulants are probably the most effective medications in the treatment of ADHD, and so they are usually the first-line choice in medication management. However, some young children are more likely to have side effects on stimulants, and many specialists will choose a non-stimulant (alpha adrenergic) medication like guanfacine and clonidine. Also, these medicines can be helpful with sleep problems and tics. If children have side effects on stimulants, we may choose a non-stimulant such as atomoxetine (Strattera).

What medications are used to treat anxiety in children?

Some SSRI antidepressants are approved for treating anxiety disorders in children. We also sometimes use medications off label, such as hydroxyzine, diazepam and buspirone.
OTHER FREQUENTLY ASKED QUESTIONS (NOT ABOUT MEDS)

*What can affect a child’s development, e.g., Drug exposure prior to birth? Genetic disorders? Prematurity? Environmental toxins? Toxic stress?*

All of these can affect children’s brain development. When we identify a child with developmental challenges, we consider all these potential causes, and we often try to find an explanation. But many times, we can’t determine a cause.

*What are the general criteria for autism diagnosis?*

There are many different kinds of autism, but all children with autism share 2 basic characteristics:

1. difficulties with social communication – verbal or non-verbal
2. repetitive behavior, resistance to change, sensory symptoms

*What are the different levels of autism?*

We generally use the terms Level 1, 2, and 3 to describe the severity or degree of the autism impairment.

1 = mild impairment, needing some support
2 = moderate impairment, needing substantial support
3 = severe impairment, needing very substantial support

We also describe children with autism according to whether they have associated cognitive or language impairment.

Mild “high functioning” autism without cognitive or language impairment was previously called Asperger syndrome, and many such individuals still identify themselves as Asperger.

*What happens in an evaluation at the Olson Huff Center? How do we differentiate certain disorders, e.g., anxiety vs autism, anxiety vs ADHD?*

Our providers have much experience in teasing these apart through careful evaluation. We take a careful history, make informed observations, perform clinical examinations, administer tests, in order to clarify diagnosis, and also understand children and families’ strengths and weaknesses.

*Which is better – an IEP or 504 Plan?*

A 504 Plan and an IEP are both intended to protect a student with a disability to ensure that they are learning in the least restrictive environment.

*When is a 504 Plan a better option?*

A 504 Plan is a better option when the student is able to function well in a regular education environment with accommodations. The 504 is generally less restrictive than the IEP, and it is also less stigmatizing.

*Examples of students who have a disability and benefit from a 504 Plan, rather than an IEP:*
- A student with an Autism Spectrum Disorder who is doing well academically, but need social skills assistance or a specific accommodations such as a visual calendar.
- A student with Attention Deficit Hyperactivity Disorder that does not need specialized instruction, but would benefit from additional time in a less distracting environment for tests and accommodations such as preferential seating or physical breaks.

**When is an IEP the better option?:**
An IEP is a better option for students with a disability that is adversely impacting education. Students who need more than just accommodations to regular education would need an IEP. Eligibility in Special Education opens the door to a variety of related services and supports.

**What is the difference between an IEP and a 504 Plan?**

<table>
<thead>
<tr>
<th>IEP vs 504</th>
<th>Individualized Education Plan (IEP)</th>
<th>Section 504 Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of law</td>
<td>Special Education - Individuals with Disabilities Act (IDEA)</td>
<td>Civil Rights - Rehabilitation Act of 1973</td>
</tr>
<tr>
<td>Department</td>
<td>Department of Education</td>
<td>Office of Civil Rights</td>
</tr>
<tr>
<td>Requirements for eligibility</td>
<td>Has a disability that: a) meets criteria under IDEA, b) significantly impacts educational performance, and c) requires specialized services</td>
<td>Has a disability that significantly impacts a major life function.</td>
</tr>
<tr>
<td>What is included?</td>
<td>Specialized education services, accommodations, related services.</td>
<td>Accommodations, modifications.</td>
</tr>
<tr>
<td>Age limits</td>
<td>IEP offered through 12th grade.</td>
<td>No age limits with a 504 plan.</td>
</tr>
<tr>
<td>Where is the plan used?</td>
<td>Educationally, through the 12th grade. Does not transfer to college.</td>
<td>School, work, and college. 504 Plans will transfer to college.</td>
</tr>
<tr>
<td>Discipline</td>
<td>A Manifestation Determination meeting must be held to determine if the offense is a manifestation of the disability by the 10th day of suspension. Services are required during long-term suspension.</td>
<td>A Manifestation Determination meeting must be held to determine if the offense is a manifestation of the disability by the 10th day of suspension. May require reevaluation.</td>
</tr>
</tbody>
</table>

www.schoolpsychologistfiles.com
A 504 Plan and an IEP have unique differences. The way in which a student qualifies for services under each plan is a major difference. It is more difficult to qualify for special education services and receive an IEP. They both require that a student have a documented disability, but there are additional requirements beyond having that disability to receive Special Education services. A student must meet criteria under one of the categories of special education. Each of those categories have specific criteria mandated by the Department of Education. In addition to having a disability, there must be clear data to support that the disability creates an adverse impact on educational performance and that specialized instruction is essential for the child to be successful. In other words, a student can have a disability, yet not qualify for special education services or an IEP.

**What are the therapies commonly provided for our patients?**

ABA – Applied Behavior Analysis – intensive (and costly) behavior therapy, using repeated trials and rewards to train specific skills, e.g., communication, or to decrease problem behaviors, e.g., tantrums. Useful in children with moderate to severe autism and other developmental disabilities. These techniques can be taught to parents to use flexibly at home.

DIR/“Floortime” – a play-based developmental, interactive treatment for young children with autism to help increase their motivation to engage and communicate with others. Skills can be taught to parents so that they can do “floortime” at home.

Structured teaching – techniques such as visual supports and structure that help children with autism and developmental disabilities to understand, to function in typical environments like school, or to cope with stressful transitions.

PCIT – an evidence-based method of coaching to enhance parent-child interaction.

CBT – Cognitive Behavior Therapy – a structured form of therapy to help children to think in more positive ways, and to decrease anxiety or depression.

Habit Reversal – a structured form of CBT specifically to help treat tics, habits and some repetitive behaviors.

Occupational Therapy

Physical Therapy

Speech Therapy

See [https://missionhealth.org/services-treatments/pediatrics/developmental-and-behavioral-medicine/](https://missionhealth.org/services-treatments/pediatrics/developmental-and-behavioral-medicine/)
Causes of Adaptive Skills Impairment

Adaptive skills are skills that develop in childhood and are essential for daily living. They include feeding, dressing, toilet training, daily hygiene, self-care, social skills, communication, and motor skills. They may be measured using questionnaires completed by parents and caregivers. Adaptive skills impairment is found in children and adults with developmental disabilities, autism, intellectual disabilities, and sometimes in association with mental illnesses. A child with adaptive skills impairment will require some supports and assistance for activities of daily living that may not be needed for a typically developing child.

Treatment for Adaptive Skills Impairment

At the Olson Huff Center treatment begins with a thorough measure of adaptive skills impairment using proven assessment scales such as the adaptive behavior assessment system (ABAS) or the Vineland-3 adaptive behavior assessment. Once adaptive skills impairments are identified, a referral can be made for evidenced based treatment. Treatments for adaptive skills impairments include Applied Behavioral Analysis (ABA), Occupational Therapy (OT), Behavioral Health Therapy, and Physical Therapy (PT). Life skills training is also helpful for older children, adolescents and young adults.

Do

- Have a qualified professional such as a licensed psychologist administer assessment scales if you suspect an adaptive skills impairment
- Seek treatment as soon as possible for your child from a licensed or certified professional if an adaptive skills impairment is identified
- Work with such professionals to identify important treatment goals and priorities in adaptive skills
- Make sure treatment is well researched and tested
- Make sure the person treating your child keeps you informed about treatment methods, treatment goals, and progress towards treatment goals
- Encourage independent effort!

Don’t

- Do not ignore signs of an adaptive skills impairment
- Do not be afraid to have your child assessed if you think there is a problem
- Do not delay starting treatment – early intervention may improve outcomes
- Do not expect the problem will just go away or be outgrown
- Do not underestimate the importance of motivation – if possible, choose goals for treatment that your child will feel motivated to work on
- Do not do things for your child that he or she can do himself/herself

Helpful books and Websites

Social skills and adaptive behavior and learners with autism spectrum disorder
Interventions for Disruptive behaviors
By Peter F. Gerhart
www.socialthinking.com
www.appliedbehavioranalyisedu.org
https://www.mentalhelp.net/articles/adaptive-behavior-life-skills/
Causes of Aggression

Aggression includes a range of hostile or violent behaviors, such as pushing, biting, spitting, hitting or kicking. It may also include threatening behaviors and property damage. Some children are aggressive when they feel threatened or overwhelmed, others learn to use aggressive behavior to dominate others or get their way. Some children are modeling behavior that they may have seen, while others lack the verbal skills to express how they feel, or are reacting to sensory issues that they have difficulty understanding.

Treatment for Aggression

At the Olson Huff Center we teach developmentally appropriate ways to set firm limits, give choices when possible, and support parents in modeling the behavior they wish to see in their children. Structure, predictability and understanding a child’s developmental stage, personal history, and environment is essential.

Do

- The cornerstone to a good behavior plan is to set firm and consistent limits. Children need to know what behavior is, and is not, permitted, and this should be consistent for everyone who cares for your child.
- Help your child find new ways to deal with their anger. Encourage children to use words to express feelings rather than fighting, and praise for nonviolent behavior.
- Instill self-control in your child. Children don’t possess an innate ability to control themselves. They need to be taught not to kick, hit, or bite whenever they feel like it. A child needs a parent’s guidance to develop the ability to keep their feelings under control and to think about their actions before acting on impulse.
- Offer a pep talk ahead of time. If you know there are situations that are difficult for your child, give him a little pep talk ahead of time. Explain the expected behavior in detail and have the child repeat it back to avoid miscommunication.

Don’t

- Avoid encouraging "toughness." In some families, aggressiveness is encouraged -- especially in boys. Parents often use the word "tough" to compliment a child. This often leads to misunderstandings.
- Don’t spank as a form of discipline. Some parents spank their child as punishment. A child who is physically punished can begin to believe this is OK to handle people when you don't like their behavior. Physical punishment can increase children’s aggression.
- Control your own temper. Children tend to mirror the behavior of their parents. If you express your anger in reasonable ways, your child will probably follow your example. Remind them that “Hands are for helping not for hurting.”
- Don’t delay consequences and don’t threaten. Children learn best when a reward or consequence is immediate. Rewards and loss of privileges need to be in proportion to the actions of your child.

Helpful books and Websites

A Volcano in My Tummy by Eliane Whitehouse, New Society Publishers; 1 edition (July 1, 1998)
Caring for Your Baby and Young Child: Birth to Age 5 (Bantam, 1998)
If You’re Angry and You Know It! by Cecily Kaiser and Cary Pillo Scholastic; First edition (October 1, 2004)
Do
Seek assessment by a psychologist including an IQ evaluation and an assessment of your child’s Adaptive Functioning (daily living and social skills).

Use this testing to identify your child’s areas of cognitive strength. Often areas of strength can be used to increase the areas of weakness. (i.e., if your child has high visual skills and low verbal skills, they can be taught to communicate using visual techniques)

Ask the practitioner to explain the test results so that you understand what it means, and have them clarify what the next steps are for your child (i.e., specific therapies.)

Meet with your local school system to identify the type of classroom and individualized education plan (IEP) that your child will thrive in. Be sure to share any medical or psychological evaluations with the school.

Some families choose to advocate for their child’s needs themselves, but most families need support. The Family Support Network (828-213-0033) or the Exceptional Children’s Assistance Center (ecac-parentcenter.org) are both reliable resources for your family throughout your child’s life.

Don’t
Do not over focus on the child’s IQ score. This score is a snapshot of their abilities, and is not always the best descriptor of a child’s overall functioning.

Do not assume that your child will not progress and learn new skills just because their IQ score seems low. Children with cognitive impairment generally don’t learn in a typical fashion, but they do learn. Sometimes they will gain skills and seem to lose them, but then with persistence and different teaching styles they will learn the skills again. Always keep trying!

Try to not get frustrated with the school system. They have your child’s best interest in mind, and want to see them progress just as much as you do. Think about your child’s teachers as part of the educational team, that includes your child’s doctors, therapists, you, and your child. It is a team effort, and keeping a positive working relationship with the team will benefit your child. (when in doubt, bring brownies to IEP meetings!)

Helpful books and Websites
American Association on Intellectual and Developmental Disabilities: www.aaidd.org

Intellectual Disability: A Guide for Families and Professionals, James C. Harris, M.D.
**Causes of Communication Impairment**

Receptive language is the ability to understand the language of others. Expressive language is the ability to communicate with others through words, signs, pictures or symbols. Speech is the ability to produce sounds – including articulation, rhythm, and voice quality – in order to communicate. Children who struggle with speech and/or language have Communication Impairment. This may include common speech articulation problems and delays in receptive and/or expressive language. Some young children may have mild speech or isolated expressive language delays that resolve over time. Others may have mixed receptive-expressive delays that may continue into the school years. Phonological disorders (understanding sounds in words) may greatly affect speaking, reading and writing. Some children may have associated Cognitive Impairment, while others have fully normal cognitive abilities. Children with autism struggle with communication, especially receptive language and social use of language (pragmatics). Some children with Motor Impairment may struggle with speech, e.g., children with cerebral palsy. Children with Communication Impairment may become frustrated and use behaviors such as tantrums or aggression to communicate their needs.

**Treatment for Communication Impairment**

Evaluation by a speech-language pathologist may help to determine the nature of a child’s communication impairment and to guide treatment. Hearing impairments need to be considered with hearing assessment. The main goal of treatment is to minimize frustration while promoting development of language. Speech therapy and associated activities at home can help to correct speech problems and improve receptive and expressive language. Some children will benefit from the use of signs or pictures or other low-tech solutions, while others may need high-tech devices to assist with functional communication. Behavioral interventions may be needed to help teach more appropriate communication behavior.

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### Do

- Talk with your child’s primary care doctor about your concerns
- Request further evaluation if needed
- Talk to your child, narrate daily events as you do them, e.g., “OK, we are in the car!”
- Respond whenever your child tries to communicate
- Use a lot of gestures and facial expression to help your child understand
- Read books aloud to your child
- Keep communication fun!

### Don’t

- Do not ignore a communication impairment
- Do not overlook hearing problems
- Do not try to make your child speak – it is unhelpful and demoralizing
- Do not overload your child with questions: try to make 2 comments for every question asked
- Avoid using complicated language
- Do not criticize pronunciation/articulation errors
- If your child is bilingual, do not think that the communication problem is just the result of learning two languages.

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**Helpful books and Websites**

- American Speech and Hearing Association [https://www.asha.org/public/](https://www.asha.org/public/)
- NC Assistive Technology Program [https://www.ncdhhs.gov/divisions/vocational-rehabilitation-services/north-carolina-assistive-technology-program](https://www.ncdhhs.gov/divisions/vocational-rehabilitation-services/north-carolina-assistive-technology-program)
What are Conduct Problems
Conduct Problems are characterized by behaviors that are aggressive, deceitful, hidden, and at times cruel. Examples of conduct problems would be behaviors like bullying others, starting fights, hurting animals, setting things on fire, breaking into someone else’s house or car, lying to get things from someone, stealing things or truancy. For some children, conduct problems may be transient, the result of lack of impulse control and negative influence of peers. Others may continue into life-long patterns of antisocial behavior (Conduct Disorder). However, with appropriate treatment, structure and supports, many children can turn these patterns of behavior around. If children are showing conduct problems, it may be important to ask questions like: What is the child trying to obtain by the behavior? What is the child trying to avoid by the behavior? What positive need or message is the child trying to communicate in this hurtful way? Looking at the behavior through this lens may help to clarify the underlying problem and find possible solutions or effective treatment.

Treatment for Conduct Problems
Treatment for conduct problems start with a parent being honest in reporting the child’s behavior to a medical or behavioral health provider that can guide them to appropriate treatment. Once that first step is made, the child and family should meet with a behavioral health provider to evaluate if the child meets criteria for Conduct Disorder or some other disruptive behavior disorder. The behavioral health provider can assist the family in formulating a plan for treatment which may include medicine as an option for helping with behavior. There is evidence that indicates the following effective interventions: Cognitive-Behavioral Therapy; Parent Training in a high quality age appropriate Discipline Model; and Multisystemic Therapy. As the word “multisystemic” implies, parents need to understand that effective treatment of conduct problems requires collaboration between the family, school, behavioral & medical providers, and at times other community agencies like Juvenile Justice. Children that have conduct problems at a younger age are at a greater risk for criminal behavior and substance use issues as adults, and therefore early identification and treatment are very important.

Do
- Discuss your concerns with your child’s primary care doctor or other knowledgeable pediatric healthcare provider
- Seek comprehensive behavioral health evaluation
- Engage in recommended treatment to address behavior concerns
- Recognize that this is a child going through a difficult time and that he/she needs your consistent love and support

Don’t
- Don’t think that serious behaviors that may fit into this category are just a phase that will go away eventually
- Don’t take the child’s behavior personally, even when it seems directed at you
- Don’t give up hope that your child’s behavior can improve with effective treatment

Helpful books and Websites
The Explosive Child, by Ross Greene
Your Defiant Child, Russel Barkley
Easy to Love, Difficult to Discipline, by Becky Bailey

http://www.bhevolution.org/public/treating_conductdisorder.page
Causes of Depression
The primary symptoms of depression revolve around sadness, feelings of hopelessness, and changes in mood. In children, there may be an increase in irritability, leading to tantrums and other disruptive behaviors. These behaviors often interfere with normal social activities, interests, and schoolwork. Children with depression commonly have changes in their sleep pattern and appetite. Depression may stem from certain significant life events such as the loss of a loved one or from stress. Children struggling with depression often have other family members who also have a depressive illness suggesting a genetic link. Depression is caused by an imbalance in the chemicals in the brain that control mood. When depression is severe it can lead children to think about suicide.

Treatment for Depression
Cognitive Behavioral Therapy or (CBT) has proven to be the most effective evidence based treatment for children with depression. This involves changing behaviors, thoughts, and beliefs that often contribute to a depressive illness. Providing parents with concrete strategies to participate in their child’s recovery is an essential part of this process. Depending on the severity of depressive symptoms, medication may also be necessary for a successful treatment outcome.

Do

- Schedule quality time with your child
- Encourage daily activities and/or exercise
- Be consistent with bedtime routine
- Provide healthy balanced meals/snacks
- Teach your child basic relaxation techniques such as deep breathing, gentle stretches, calming activities, i.e. drawing, listening to music, puzzles, reading a story, etc.
- Provide consistency with structure, routine, predictability, and clear expectations
- Assist your child to find a healthy balance between school, homework, afterschool activities, chores, screen time, free time with friends, and alone time.
- Be a good role model by practicing good self-care

Don’t

- Don’t forget to make scheduling quality time with your child a priority
- Don’t allow your child to isolate and withdraw from friends and family
- Don’t let your child stay up late playing video games
- Don’t have a lot of sugary snacks in the house that are easily accessible to your child
- Don’t sign your child up for more than one or two afterschool activities
- If medication is necessary, don’t forget to make sure your child takes the medication consistently as prescribed by his/her doctor
- Don’t hesitate to ask for help when you feel overwhelmed

Helpful books and Websites
“Think Good-Feel Good: A Cognitive Behavior Therapy Workbook for Children and Young People,” by Paul Stallard
www.kidshealth.org/depression
https://childmind.org/topics/concerns/depression/
Causes of Hyperactivity/Impulsivity

Hyperactivity and impulsivity are impairments of self-control, often associated with attention problems. These impairments are typically seen in children with ADHD, and they may interfere with school performance, peer relations, and behavior at home and in the community. Hyperactivity and impulsivity can be caused by a variety of factors such as heredity, low birth weight, exposure to toxins, medical conditions, sleep deprivation, trauma and stress.

Treatment for Hyperactivity/Impulsivity

Treatment can include behavioral therapy and medication. Behavioral therapy can help children learn to better control impulses, and give families effective strategies to improve organization and structure. Educational interventions in school are also very important. Medications don’t cure hyperactivity, but they can manage or reduce the symptoms and improve coping strategies.

Do

Provide your child with planned times where they will be able to get up and move, especially in situations where they are expected to sit for long periods of time.

Get your child involved in a sport, or other physical activity that will allow them to burn energy such as a team sport (soccer) or an individual sport (swimming).

Acknowledge times when you see your child take their time, and think through their actions. Do this with specific compliments like, “It was so good when you walked away from your sister when you got upset” versus “good job playing with your sister.”

Help your child learn in a hands on and visual way. Teach them to draw pictures or make up rhymes to remember facts, make up a game that involves movement, or use Legos to represent math concepts.

Plan ahead for situation that have been difficult in the past (i.e., church or a restaurant). Review the expectations with your child before entering, set up an incentive for positive behavior, and stick with your plan.

Practice forgiveness, and remember that your child can’t control their behavior all of the time.

Don’t

Do not rely on medication to fix your child’s challenges. While medication can certainly reduce symptoms, it is important that your child still learn strategies that will benefit them throughout their life.

Don’t give long winded lectures about what your child is doing wrong. Instead provide brief, immediate feedback.

Don’t rely solely on punishment, but instead consider developing specific expectations that can be rewarded immediately. It is difficult for children to wait long periods of time for a reward, and if the reward doesn’t happen close to the positive behavior, it becomes less effective.

Don’t give up on new strategies that you try. Behaviors take a long time to develop, and therefore they take a long time to change. When you are trying a new technique, be consistent and be sure all adults involved are responding in the same way.

Don’t assume that all teachers will know how to deal with your child appropriately. Instead, find out if your child would qualify for a 504 plan at school that will support their impulsivity. Try to work with a teacher who has done well with your child in the past, so they can suggest strategies that worked for them.

Helpful books and Websites

Taking Charge of ADHD, Russell Barkley

Smart But Scattered, Peg Dawson
**Causes of Inattention**

Inattention makes it difficult to focus on the task at hand. Children with inattention miss details and become distracted easily. Inattention can also cause a person to become bored quickly, be disorganized, struggle with motivation, and seem to not listen when spoken to. Inattention is commonly seen in children with ADHD, and may be caused by a variety of factors such as heredity, low birth weight, exposure to toxins, sleep deprivation, medical conditions, trauma and stress.

**Treatment for Inattention**

Treatment can include behavioral therapy and medication. Behavioral therapy can help children learn to listen and focus more strongly, reward effort and motivation, and give families effective strategies to improve organization and structure. Educational interventions in school are also very important. Medications don’t cure hyperactivity, but they can manage or reduce the symptoms and improve coping strategies.

<table>
<thead>
<tr>
<th>Do</th>
<th>Don’t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Find a behavioral therapist who can guide you in strategies to support your child such as a positive behavior support system that rewards the positive behaviors.</td>
<td>Do not rely on medication to fix your child’s challenges. While medication can certainly reduce symptoms, it is important that your child still learn strategies that will benefit them throughout their life.</td>
</tr>
<tr>
<td>Limit screen time to less than 2 hours a day.</td>
<td>Don’t give long wined lectures about what your child is doing wrong. Instead provide brief, immediate feedback.</td>
</tr>
<tr>
<td>Keep your child’s work area free of distractions. Consider providing them with ear plugs if your house is loud.</td>
<td>Don’t rely solely on punishment, but instead set specific goals that can be rewarded immediately with incentives. It is difficult for children to wait long periods of time for a reward, and if the reward doesn’t happen close to the positive behavior, it becomes less effective.</td>
</tr>
<tr>
<td>Create a routine for the morning, afternoon, and weekends, and stick to it.</td>
<td>Don’t expect that your child knows the family expectations or routines that are completed often. Instead, support them by provided written reminders such as a note card next to their homework area that says “stay focused, show your work, ask questions” or a morning checklist “get dressed, eat breakfast, brush teeth, get shoes &amp; backpack, etc.”</td>
</tr>
<tr>
<td>Be brief and clear when giving your child instructions. If they don’t seem to remember what was said, write it down in a checklist format.</td>
<td>Don’t give up on new strategies that you try. Behaviors take a long time to develop, and therefore they take a long time to change. When you are trying a new technique, be consistent and be sure all adults involved are responding in the same way.</td>
</tr>
<tr>
<td>Help them understand the passage of time by using timers, or setting up specific times that they need to finish tasks. Give them a warning when there is 5 more minutes.</td>
<td></td>
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<td>Find out if your child qualifies for a 504 plan at school. Try to work with a teacher who has done well with your child in the past, so they can suggest strategies that worked.</td>
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<td>Practice forgiveness, and remember that your child can’t control their behavior all of the time.</td>
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**Helpful books and Websites**

- Taking Charge of ADHD, Russell Barkley
- Smart But Scattered, Peg Dawson
**Causes of Learning Difficulties**

Learning difficulties are generally caused by something affecting the development of the brain. This may occur before or during birth, or in early childhood. A variety of factors can cause learning problems, and sometimes the cause is unknown. Possible causes could include an inherited condition, chromosomal abnormality, complications during birth, premature birth, or exposure to toxins during pregnancy. Learning problems can relate to a variety of brain functions: how the brain process sounds, short and long term memory, the ability to visualize letters and words, attention and focus, organization and planning, as well as the motor function of writing.

**Treatment for Learning Difficulties**

Treatment will depend on your child’s needs, but should be designed to build on their strengths and compensate for their weaknesses. Treatment can include special teaching techniques, the use of assistive technology, visual and hands on learning strategies, memory aids, and creating a structured and calm learning environment at home and school. Some children benefit from Speech Therapy and Occupational Therapy.

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**Do**

- Seek out an assessment at school, or privately, to assess for a learning disorder, as well as cognitive strengths and weaknesses
- Establish consistent and positive communication with your child’s teachers
- See what therapy and tutoring your child would qualify for at school and privately
- Praise your child’s effort and strengths
- Create a quiet calm learning space in your home
- Get a library card at your public library
- Establish a routine for reading together daily
- Figure out how your child learns best, just reading over something might not be enough
- Try to make learning fun, interactive, and visual. Draw pictures, make up rhymes, and use mnemonic tricks

**Don’t**

- Don’t punish or reprimand a child for difficulties related to their learning problems
- Don’t assume that there is a disability just because their learning is delayed
- Don’t adopt a one size fits all approach, all children learn differently
- Don’t allow any frustration you feel toward your child’s progress effect how you interact with them
- Don’t just let them get help at school, children need to be supported and encouraged at home as well
- Don’t organize or do their work, homework folder, backpack, etc. for them, instead set up systems, checklists, reminders, and support that will allow them to learn how to do these tasks independently

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**Helpful books and Websites**

readingrockets.com  ldaamerica.org  ldonline.org  dyslexiahelp.umich.edu  khanacademy.org
Smart But Scattered, Peg Dawson  Overcoming Dyslexia, Sally Shaywitz
Causes of Motor Impairment

A young child’s motor development includes tone, posture and movement. Motor development follows a predictable sequence (“milestones”), reflecting the functional head-to-toe maturation of the central nervous system. Motor delays are common and vary in severity and outcome. Some late walkers achieve typical milestones at a later age, with no long-term impairment. Some continue to have motor impairments that affect daily living, e.g., mobility, coordination, self-care and recreation. Six percent of children have developmental coordination disorder (DCD), and 3 per 1000 have cerebral palsy (CP). Motor impairment may be the first or most obvious sign of a global developmental disorder. When motor impairment is severe or worsening, a specific neuromuscular disorder is more likely to be diagnosed. Establishing a specific diagnosis can be helpful in relieving parents’ uncertainty and in planning treatment. Neurologic examination and use of diagnostic tests may be helpful. For children with neuromuscular disorders for which treatments are available, outcomes may be improved when therapy is implemented early.

Treatment for Motor Impairment

Referral of young children (0-3 years) with motor impairment to Early Intervention is a helpful start. Physical therapy (PT) can be helpful in improving motor function, and is an essential part of the management of children with CP. Occupational therapy (OT) may focus on sensory processing, motor planning and the development of fine motor skills. For children whose motor impairments affect feeding and speech, Speech therapy may be additionally important. Some children with weakness and associated orthopedic challenges may benefit from bracing or other adaptive equipment. Some children with CP who have spasticity may need medication or other treatments to decrease spasticity. Parents and therapists should set goals of treatment to improve a child’s functional abilities, and older children should be encouraged to participate in setting goals. Children with long-term motor impairment should receive needed therapy services through schools, but they may also need intermittent or more intensive therapy services to achieve particular functional goals.

Do

- Discuss your concerns with your child’s primary care doctor
- Maintain communication with therapists in the community and in school
- Share with them your short term and long term goals for your child’s functional abilities
- Encourage participation in recreational activities, providing helpful accommodations and supports
- Think “differently-abled” - not disabled.
- Understand that “Normal” is a strange idea!

Don’t

- Do not invest time and resources in unproven or potentially harmful treatments
- Do not focus on “fixing” a disability
- Do not forget that it is all about enhancing function, activity and participation!

Helpful books and Websites

CanChild  
www.canchild.ca

CP Now  
www.cpnowfoundation.org

United Cerebral Palsy  
www.ucp.org

Retro Toddler, by Anne Zachry
### Causes of Oppositional/Defiant Behavior

Oppositional and Defiant Behavior is a pattern of persistent anger, irritability, defiance and argumentative behavior which is outside the usual range for a child’s age. These behaviors usually cause impairment in more than one setting. Symptoms can begin in preschoolers and if they persist may be given the diagnosis Oppositional Defiant Disorder (ODD). Some children with ODD may develop Conduct Problems, a pattern of aggressive and antisocial behavior. There is no single biologic, neurologic or genetic cause of ODD. The causes may include difficult temperament, lack of self-regulation, inconsistent or harsh discipline, abuse, neglect and other mental health and developmental disorders such as ADHD, Autism, anxiety, depression and learning disorders.

### Treatment for Oppositional/Defiant Behavior

Treatment begins with a comprehensive evaluation to determine the factors that underlie the behaviors. Problem behaviors need to be addressed by appropriate parenting techniques, behavior modification and supports in school, and, at times, medication. Parent management training, with a focus on positive parenting, is usually essential. Individual psychotherapy can help some young children to develop anger management techniques. Social skills training can help children learn to see things from the perspective of others and improve flexibility. Family psychotherapy can help improve communication within the household. Cognitive problem solving skills can be incorporated with other therapies.

### Do

- Pick your battles
- Reward compliant behaviors with praise and positive reinforcement
- Set clear, age appropriate expectations with both positive and negative consequences which can be enforced.
- Take a time-out break for yourself if you are feeling overwhelmed.
- Empathize with your child’s desires
- Help them problem solve ways to reach their goals that are based on positive behavior
- Use more positive than negative contingencies
- Maintain similar behavioral management strategies among all care givers.
- Seek help for yourself. You cannot parent your child if you are stressed, depressed or anxious.

### Don’t

- Do not sweat the small stuff
- Do not give in to child’s demands when they tantrum
- Do not argue or make threats– set consequences.
- Do not use corporal punishment - encourage children to take time-out breaks for themselves when upset.
- Do not expect a child to behave because you are the parent and you tell them what to do.
- Do not let children play one adult against another
- Do not make demeaning comments that can undermine a child’s self-esteem.

### Helpful books and Websites

**Your Defiant Child** by Russell Barkley  
**The Explosive Child** by Ross Greene  
**Easy to Love Difficult to Discipline** by Becky Bailey  
[https://childmind.org/topics/disorders/behavior-and-conduct-disorders/](https://childmind.org/topics/disorders/behavior-and-conduct-disorders/)
# Repetitive Behaviors
Repetitive behaviors are things that kids do over and over. The persistence of these behaviors can be worrisome to parents, disruptive to teachers, and difficult to the child who is doing them. There are different kinds of repetitive behavior, each needing a different approach. Tics are brief involuntary movements or vocalizations. Stereotypies - sometimes called “stimming” – are repetitive movements which kids may do during times of excitement or upset, and may have a calming effect for the child. Repetitive behaviors – such as compulsive touching or counting - that kids feel like they have to do in order to escape a feeling of anxiety are seen in kids who have Obsessive Compulsive Disorder (OCD). Children with autism may organize or line up toys in a particular way to establish a desired order or pattern. Body repetitive or grooming behaviors like skin picking or hair pulling may be exaggerated by stress or certain medications. Some repetitive behaviors are simply habits like thumb sucking, minor nail biting, or hair twirling.

## Treatment for Repetitive Behaviors
The category that a repetitive behavior falls in will determine if and how that behavior will be targeted in treatment. Tics can be addressed with behavioral interventions, and medication if necessary. Stereotypies, which often serve the function of self-soothing, would not likely be a target of treatment in that they are helpful to the child in some way. Compulsive behaviors are generally rooted in anxiety and can be addressed with behavioral interventions and/or medication. Body repetitive behaviors can be targeted for change if they are creating marked distress for the child such as skin lacerations from picking or bald patches from hair pulling. Likewise, habits can be addressed if they are disruptive to day to day functioning in some manner.

## Do
- Discuss your concerns with your child’s primary care doctor or other knowledgeable pediatric healthcare provider
- Seek comprehensive behavioral health evaluation to help determine which category of repetitive behavior is happening
- Engage in recommended treatment to address behavior concerns
- Recognize that this is a child going through a difficult time and that he/she needs your consistent love and support

## Don’t
- Do not just tell your child to “Stop it” over and over again
- Do not punish the child in an effort to get him/her to stop the behavior
- Do not shame the child for the behavior
- Do not assume the behavior will just go away on its own - even though sometimes this can be true!

## Helpful books and Websites
- **What Makes Ryan Tick?**, by Susan Hughes
- **The Hair Pulling "Habit" and You: How to Solve the Trichotillomania Puzzle**, by Ruth Goldfinger Golomb
- **What to Do When Your Brain Gets Stuck: A Kid’s Guide to Overcoming OCD**, by Huebner & Matthews
- Tourette Syndrome Association [https://www.tourette.org/](https://www.tourette.org/)
- Child Mind Institute [https://childmind.org/topics/disorders/tourettes-and-tic-disorders/](https://childmind.org/topics/disorders/tourettes-and-tic-disorders/)
**Causes of Resistance to Change**

Children and teens with autism spectrum disorders (as well as other intellectual disabilities) often exhibit a resistance to change and rigidity about various aspects of their lives. They may present with meltdowns (intense anger, crying and even aggression), increased anxiety, and refusals to comply with demands where there are changes to their usual schedule. There may be refusals to try new activities or foods, failure to adjust their behavior to novel circumstances, and reacting negatively to changes in routine. This insistence on sameness often results from a failure to appreciate the “big picture” of the world in favor of a more situation-specific processing style. Focus on details rather than concepts (e.g., yesterday we went out to play at the park at 11:00, but today we will do something different at 11:00) is often seen. Some children may look for particular details in their environment that they expect to be there and if they are not, they can get upset. Receptive language difficulties may make it harder for the child to understand why things change on a daily basis or why one event may take priority over another. Finally, a relative lack of broader play skills may result in a child playing with a toy or materials in the same way over and over rather than in a more varied manner.

**Treatment for Children who Resist Change**

In many cases, preparation for upcoming events is the best first approach to addressing resistance to change. Visually-depicted schedules or written schedules can help the child see the order of the day, and changes can be pointed out. Many children can learn to work through changes with checklists that might show a different order for doing something in a sequence or for additions to a sequence. Reassurance that change can be “okay” and is expected in life can be addressed with explanations through Social Stories ™.

<table>
<thead>
<tr>
<th><strong>Do</strong></th>
<th><strong>Don’t</strong></th>
</tr>
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<tbody>
<tr>
<td>✷ Realize that changes can produce anxiety for persons with ASD as much or more than they may for neurotypicals.</td>
<td>✷ Don’t avoid changes, but strive to help the child understand them</td>
</tr>
<tr>
<td>✷ Use visual schedules to help (e.g. objects, first-then, pictures, written) show what will happen</td>
<td>✷ Do not expect your child to figure out a new routine on their own, they often need assistance from parents or teachers</td>
</tr>
<tr>
<td>✷ Introduce changes to your child’s day to help them learn to be more flexible</td>
<td>✷ Do not get angry at the child’s reaction, calmly inform about changes with reference to things the child can “see” to help with processing</td>
</tr>
<tr>
<td>✷ Praise the individual for handling changes</td>
<td></td>
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<tr>
<td>✷ Introduce new routines when an old routine is not working for the individual (e.g., they are too rigid)</td>
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<tr>
<td>✷ Use timers to help with “how long” an activity; use checkboxes to show “how many” (4x and then it is “finished”)</td>
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<tr>
<td>✷ Clarify the schedule and expectations in different environments (school vs. home) to increase greater flexibility</td>
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</tbody>
</table>

**Helpful books and Websites**

Refer to materials from the UNC TEACCH program (www.teacch.com)

*Visual Strategies for Improving Communication: Practical Strategies for School & Home* by Linda Hogdon, M.ED, CCC-SLP
Causes of Stereotypic or Self-Stimulatory Behavior

A number of children with autism or intellectual disability will exhibit stereotypy (pronounced stare-e-aw-tip-ee), self-stimulatory behaviors including finger movements, hand or arm-flapping, body posturing, body rocking (side-to-side, or back and forth, seated or standing), visual staring at lights, rubbing of skin or objects, smelling objects or people, among others. Researchers have suggested various reasons for why a person may engage in stereotypic behaviors. One theory suggests that the behavior provides the person with sensory stimulation; thus the person engages in these behaviors to excite or arouse the nervous system. Another set of theories state that these behaviors are exhibited to calm a person. That is, the environment is too stimulating and the person is in a state of sensory-overload. They would therefore engage in the behavior to block out the over-stimulating environment.

Treatment for Self-Stimulatory Behavior

There are numerous ways to reduce or eliminate stereotypic behaviors, such as increasing exercise as well as providing the individual with alternative, more socially-acceptable forms of stimulation (e.g., chewing on a rubber tube rather than biting one’s arm or clasping one’s hands when excited rather than flapping hands, or offering the individual an object to fidget with). In some cases, these behaviors can be positive reinforcers for the person if they are allowed to engage in them after completing a task.

Do

- Look for environmental situations that tend to elicit these behaviors more often
- Be open to thinking that the person may engage in the behavior to express pleasure and excitement with a situation or topic (but can’t express this verbally)
- Praise the individual for alternative ways of responding to a sensory over-stimulating situation
- Explore various “fidgets” (Koosh balls, Chewelry, certain fabrics or objects) that are comforting
- Teach calm down techniques such as deep breathing and progressive muscle relaxation as alternatives
- Teach an alternative way to use a material or object and increase play skills

Don’t

- Don’t punish a child for engaging in the behavior; gently remind about other ways to engage hands, fingers, mouth, nose, etc.
- Don’t allow others to tease the person for engaging in the behavior; seek to help them understand
- Don’t allow the behavior to go unchecked if it interferes with productive hand use or task completion
- Do not allow your child to isolate and avoid being around people by solely engaging in these behaviors for longer periods of time.

Helpful books and Websites

Search “Self-Stim Behavior” at www.AutismSpeaks.org
Michigan’s Friendship Circle—Special Needs Resources at www.friendshipcircle.org “The Causes of Stimming” in Resources section
**Causes of Sensory Impairment**

Some children are unusually sensitive to noise, touch, smells, tastes and textures. Others seem to crave such sensory inputs. If these sensory issues cause significant challenges for a child, they may be called a sensory impairment. Sensory impairment may occur because signals from sensory receptors are either not detected or not organized into appropriate responses. There are many potential causes. Research suggests that there is a genetic link that can be passed down in families. Risk factors such low birth weight and prematurity are also suspected causes. Sensory impairment is often seen in children with developmental disorders such as autism and ADHD. There may be a link with anxiety disorders. Also, environmental circumstances may play a role, e.g., neglect, abuse and institutional orphanage care may lead to sensory impairment.

**Treatment for Sensory Impairment**

Occupational therapy (OT) is often used to treat sensory impairments. At the Olson Huff Center, our OTs are experts in sensory impairments, helping children learn to organize and process sense of smell, visual perception, sensitivity to touch/clothing textures, feeding/food texture problems, auditory processing, motor planning, balance and coordination, and sensory over/under reactivity. OTs will also provide parents with tools and techniques to help modify the environment at home and in the community to help prevent sensory processing issues becoming impairments.

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**Do**

- See your pediatrician or primary care physician if you notice differences in how your child reacts to sensory stimulation.
- Have your child evaluated by your pediatrician, a developmental pediatrician, audiologist, speech therapist, or an occupational therapist if you notice signs of sensory impairment.
- Follow-up with treatment as soon as possible following recommendations from qualified professionals.
- Incorporate accommodations at home and at school to help your child tolerate sensory stimuli without feeling overwhelmed.

**Don’t**

- Do not allow symptoms to persist.
- Do not just hope the symptoms go away or that the child will grow out of them.
- Do not force the child to tolerate environmental stimuli when overwhelmed.
- Do not punish or discipline the child for behaviors associated with sensory impairment.
- Do not assume that the sensory problems will always be the same – for most children they improve over time.

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**Helpful books and Websites**

<table>
<thead>
<tr>
<th>Star Institute</th>
<th><a href="http://www.spdstar.org">www.spdstar.org</a></th>
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<tbody>
<tr>
<td>Child Mind Institute</td>
<td><a href="https://childmind.org/topics/concerns/sensory-processing/">https://childmind.org/topics/concerns/sensory-processing/</a></td>
</tr>
<tr>
<td>The out of Sync Child</td>
<td>Carol Stock Kranowitz, M.A.,</td>
</tr>
<tr>
<td>Raising a Sensory Smart Child</td>
<td>Lindsey Biel, M.A., OTR/L</td>
</tr>
</tbody>
</table>
### Causes of Separation Anxiety

Environmental factors that often contribute to separation anxiety in children may include some type of loss. It could be the death of a relative or pet; an illness of a relative; a change of schools; parental divorce; a move to a new neighborhood; or when there has been a period of separation from a primary caregiver(s). Separation anxiety is most common in children ages six to nine years old. Some children inherit separation anxiety and may not necessarily have external stressors.

### Treatment for Separation Anxiety

At Olson Huff Center we treat separation anxiety using an evidenced based approach called Cognitive Behavioral Therapy. We teach children to recognize their anxious feelings and physical reactions related to separation. We assist children to become aware of their thoughts about separation and introduce them to various coping strategies. For younger children we may use a form of play therapy to help them understand their feelings and to teach them how to cope with feelings related to separation. Parents are taught specific interactive skills to assist their child in overcoming fear of separation.

### Do

- Focus on fun activities at school or day care
- Help your child get settled at school or day care and then leave
- Let your child know you will return to pick them up
- Remind your child how you have returned for them in the past
- Reward targeted and desired behaviors
- Remain calm, matter of fact, and firm
- Remove uncertainty – describe the specifics of what the child might expect
- Praise any efforts in the direction of independence

### Don’t

- Don’t let your child stay home when they do not want to go to school or day care
- Don’t surprise your child with a change in plans or activities
- Don’t let your child focus on what unlikely bad things might happen
- Don’t punish for behaviors that are a result of separation anxiety/fears
- Don’t sneak out the door without saying good-bye
- Don’t say things like, “I wish I didn’t have to go,” or “I will miss you all day, too.”
- Don’t hover over your child, question, or reassure excessively
- Don’t discourage independence or self-reliance

### Helpful books and Websites

- “Freeing Your Child from Anxiety,” by Tamar E. Chansky, Ph. D  
  www.childanxiety.net
- “What to Do When You Worry too Much,” by Dawn Huebner, Ph. D  
  www.adaa.org
- https://childmind.org/topics/concerns/anxiety/
Do

- Have a bedtime routine and bedtime rules
- Make sure your child goes to bed and gets up at the same time every day, (even on weekends)
- Make your child’s bedroom inviting, (if your child likes a particular super hero, invest in super hero sheets, etc.)
- Encourage quiet time before bed by engaging them in a calming activity i.e. puzzle, reading, or drawing
- Make sure your child has something comforting to sleep with, (favorite stuffed animal or blanket)
- Spend a few quality moments with your child once they are in bed and ask about their day
- Make sure your child has used the bathroom, had a drink of water, gotten hugs, etc. before bedtime
- Walk your child back to their bed if they come to visit you during the night
- If your child screams and cries at night, tell them you will check on them every five minutes until they fall asleep

Don’t

- Don’t allow electronics in the bedroom at night, (use a sound machine or relaxing music instead)
- Don’t eat sugary snacks or drink caffeine for at least two hours before bed
- Don’t allow electronics for at least an hour before bedtime
- Don’t engage in stimulating activities and exercise just before bed
- Don’t permit loud noises or bright lights in the bedroom
- Don’t allow naps during the daytime
- Don’t punish your child for not sleeping if they stay in their bed and remain quiet, (you can’t force a child to sleep)
- Don’t allow your child to stay up as long as they want
- Don’t let your child sleep in bed with you. Otherwise they won’t learn to fall asleep on their own

Helpful books and Websites

“Solve Your Child’s Sleep Problems,” by Richard Ferber, M.D.
“Sleep Better!” by V. Mark Durand, Ph. D.
www.sleepeducation.org/children
www.clevelandclinic.org/childhoodinsomnia
### Causes of Social Anxiety

There are three main causes of social anxiety: genetics, environment, and upsetting events that may trigger social anxiety. A child with social anxiety often has one or more family members who also struggle with anxiety. If a parent is overly cautious or shy themselves, their modeling could also contribute to a child’s social anxiety. Finally, a personal traumatic event can be the cause of social anxiety. For example, being shamed by a teacher in front of the class or not being invited to a party when everyone else was.

### Treatment for Social Anxiety

At Olson Huff Center we use an evidence based approach called Cognitive Behavioral Therapy, (CBT). Our thoughts, feelings, and behaviors are all interrelated. For example, a child might change the thought, “I know I’m going to say something stupid,” to “It’s ok if I make a mistake, everyone makes mistakes.” He/she might feel less anxious with this new thought and therefore be more willing to attend a social event. We also include an approach called Exposure Therapy. This involves preparing the child to face a feared social situation by taking small steps in the direction of his/her ultimate goal. Parents are taught ways to encourage their child to be more socially independent.

### Do

- Challenge your child’s negative thoughts
- Let your child know that you believe in them
- Be patient
- Praise them when they engage in a social situation that has caused anxiety in the past
- Point out when none of the negative predictions actually happen
- Teach calm down techniques such as deep breathing and progressive muscle relaxation
- Encourage them to join a club with children who have similar interests
- Teach social skills. Practice at home by role playing with your child

### Don’t

- Don’t allow your child to stay home from school because they are socially anxious
- Don’t push too far outside his/her comfort zone
- Don’t tease him/her for being shy or easily embarrassed
- Don’t reinforce negative beliefs
- Don’t role model avoidance of social situations
- Don’t reassure too much, once or twice is plenty
- Don’t allow your child to isolate and avoid being around people
- Don’t get angry or frustrated with your child when they are socially anxious. This will only make the situation worse
- Don’t make excuses for them so they can avoid being social

### Helpful books and Websites

- The Shyness & Social Anxiety Workbook for Teens, by Jennifer Shannon, LMFT  [www.childanxiety.net](http://www.childanxiety.net)
- Freeing Your Child from Anxiety, by Tamar E. Chansky, PH.D.  [www.adaa.org](http://www.adaa.org)
- [https://childmind.org/topics/concerns/anxiety/](https://childmind.org/topics/concerns/anxiety/)

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### Causes of Social/Peer Problems

Some children are simply shy and slow to approach unfamiliar people. When children become more fearful, isolated or withdrawn, that may indicate the onset of social anxiety or depression. Also, children who are victims of abuse, bullying or social rejection may become withdrawn. Children – including some with autism – may want to fit in socially with peers but they may have difficulty with social skills and communication. Other children – including some with ADHD – may be outgoing, but impulsive, aggressive or disruptive. They may lose friends, get into fights and suffer peer rejection.

### Treatment for Social/Peer Problems

Treatment begins with understanding and support. Not every child has to be popular. Identifying a child’s strengths and interests may lead to ideas about activities and groups that would be a good match. Playdates and structured social activities may provide opportunities to practice social skills and develop friendships. Some children may benefit from participating in a social skills group. A guidance counselor or therapist may be helpful. If there is an underlying diagnosis of ADHD, medical treatment may help to improve peer relationships.

<table>
<thead>
<tr>
<th><strong>Do</strong></th>
<th><strong>Don’t</strong></th>
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</thead>
<tbody>
<tr>
<td>❖ Be a good social role model for your child</td>
<td>❖ Don’t embarrass your child in public situations</td>
</tr>
<tr>
<td>❖ Protect your child from embarrassment</td>
<td>❖ Don’t punish your child for being shy</td>
</tr>
<tr>
<td>❖ Practice social skills at home and in play</td>
<td>❖ Don’t teach your child to settle conflicts with physical aggression</td>
</tr>
<tr>
<td>❖ Arrange play dates and social activities and monitor the situation (be a fly on the wall)</td>
<td>❖ Don’t reinforce aggressive or disruptive behavior by expressing your approval</td>
</tr>
<tr>
<td>❖ Provide constructive feedback and advice</td>
<td>❖ Don’t set your child up for failure by forcing them into social situations that are not likely to go well for them</td>
</tr>
<tr>
<td>❖ Look for opportunities to praise your child’s positive social behavior</td>
<td>❖ Don’t have unrealistic expectations, e.g., a child who is impulsive and hyperactive should not be expected to sit completely still without some fidgeting</td>
</tr>
<tr>
<td>❖ Establish appropriate consequences for aggressive behavior</td>
<td>❖ Don’t focus too much on your child’s weaknesses</td>
</tr>
<tr>
<td>❖ Talk with the teacher and school guidance counselor about your concerns</td>
<td>❖ Don’t compare your child to other children or siblings and ask why he/she can’t be more like them</td>
</tr>
<tr>
<td>❖ Encourage participation in structured social activities, e.g., cub scouts, sports, church groups</td>
<td>❖ Don’t allow your child to isolate and avoid social situations</td>
</tr>
<tr>
<td>❖ Accept that shy behavior may be entirely normal</td>
<td></td>
</tr>
</tbody>
</table>

### Helpful books and Websites
