Empowering Youth: Coordinated Care for Youth with Autism in CD Custody

An In-Service Training for Foster Parents

Hosted By: Dr. Toby Mills, PhD., LCSW

Center for Child Well-Being
University of Missouri

And in partnership with: MU Thompson Center, Children's Mercy Hospital, Knights of Columbus Foster Care Autism Clinic, the Kansas Center for Autism Research & Training, The Department of Mental Health Children's Office, & The Foster & Adoptive Care Coalition

Training Agenda

ASD Overview Typical vs. Atypical Development Differences Between IDD & ASD ASD & Trauma, Screening, Evaluation & Assessment	Thompson Center
Common Bx's and Bx Challenges	Children's Mercy Hospital
Psychotropic Medications & Clinical Interventions	Knights of Columbus
Applied Behavioral Analysis	Kansas Center for Autism Research and Training
Department of Mental Health Services and Policies	Department of Mental Health
Grooming, Hygiene, Toilet Training Foster Parent Self-Care Strategies	Foster and Adoptive Care Coalition
Closing	

Thompson Center for Autism & Neurodevelopment
University of Missouri

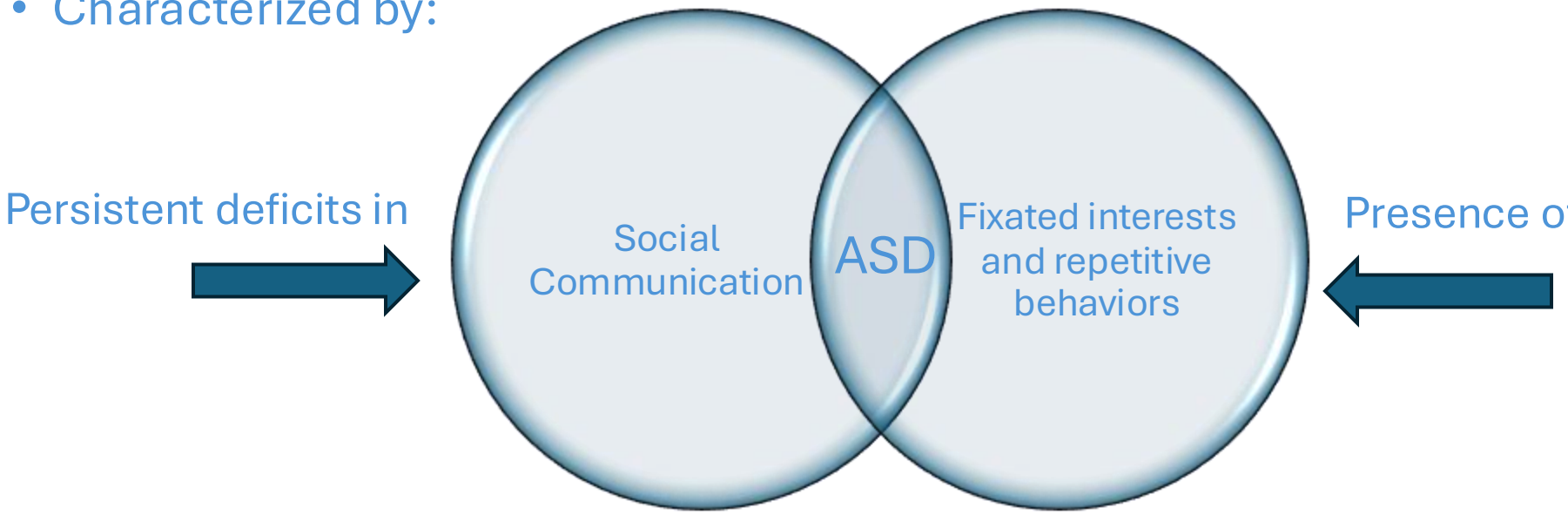
By: Dr. Joanna Mussey, PhD., ABPP & Megan Leonard, M.A, Doctoral Intern

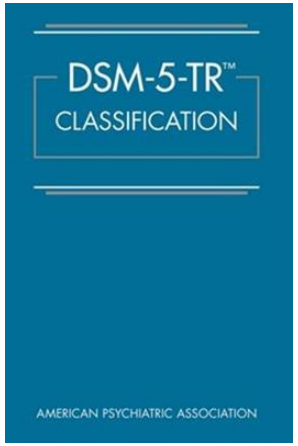
Training Section 1:

- ASD Overview
- Signs of typical and atypical development
- Differences between IDD and ASD
- ASD and Trauma- differences, similarities and co-occurrences
- Screening, evaluation and importance of validated assessments from qualified professionals.

Overview of Autism Spectrum Disorder (ASD)

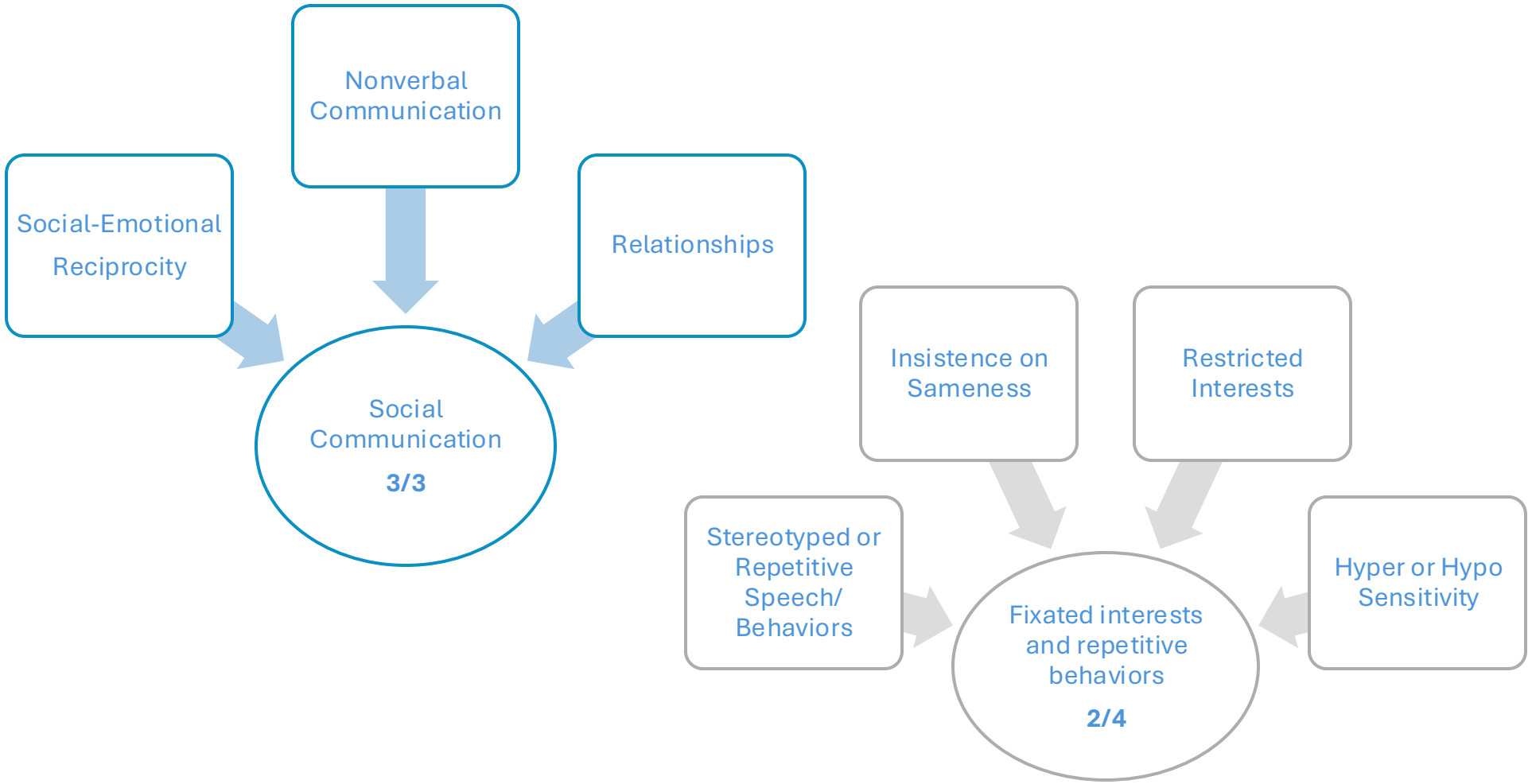
- A neurodevelopmental disorder assumed to be neurobiological
- Characterized by:





- Symptoms must be present in early developmental period (but may not become fully manifest until social demands exceed limited capacities)
- Symptoms cause clinically significant impairment in current functioning
- Not better explained by Intellectual Developmental Disorder (Intellectual Disability) or Global Developmental Delay

DSM-5
Autism Spectrum Disorder Criteria



Diagnosed on a continuum of symptom severity

Social Communication

Social Emotional Reciprocity

No language …… Impaired conversation

Not initiating interactions …….. Unusual social approach

Nonverbal communication (gestures, facial expressions, eye contact)

Limited use …… Unusual use

Not socially modulated ……. Inconsistently modulated

Relationships and imagination

Socially aloof …… Socially interested but odd

Limited social play …… Limited make-believe

Fixated interests and repetitive behaviors

Stereotyped or repetitive speech/ behaviors

Non-functional play …… Repetitive play

Echolalia …… Overly formal

Insistence on sameness

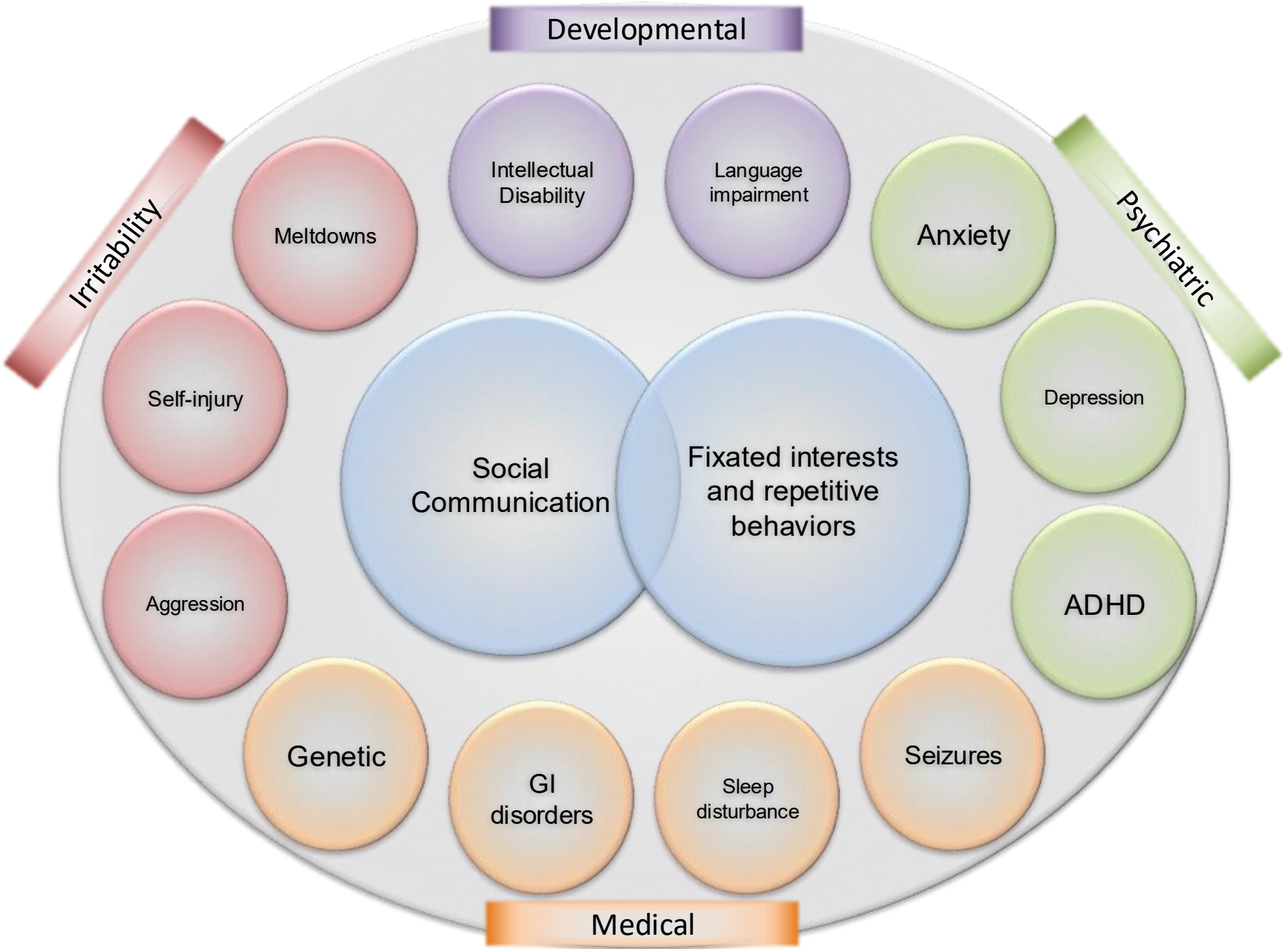
Verbal rituals …… Rigidity

Restricted interests

Narrow interests …… Unusual interests

Unusual sensory sensitivity

Over-responsive ……. Unusual sensory interests


Developmental
Irritability
Psychiatric
Medical
Intellectual Disability
Language impairment
Meltdowns
Anxiety
Self-injury
Depression
Social Communication
Fixated interests and repetitive behaviors
Aggression
ADHD
Genetic
GI disorders
Sleep disturbance
Seizures

Developmental Expectations and Milestones

- Expectations depend on developmental level

Resources:

- General child development
  - CDC developmental milestones: *Learn the Signs. Act Early*
  - Evidence-Informed Milestones for Developmental Surveillance Tools published in *Pediatrics* (Zubler et al., 2022)
- Social Communication
  - SoCo Growth Charts (https://scgc.babynavigator.com)

CDC Learn the Signs. Act Early.

SoCo Growth Charts™ Social Communication Growth Charts

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Red Flags for Autism/Atypical Development
(From Autism Speaks)

- **By 6 months:**
  - Few or no big smiles or other warm, joyful and engaging expressions
  - Limits or no eye contact
- **By 9 months:**
  - Little or no back-and-forth sharing of sounds, smiles, or other facial expressions
- **By 12 months:**
  - Little or no babbling
  - Little or no back-and-forth gestures such as pointing, showing, reaching or waving
  - Little or no response to name
- **By 16 months**
  - Very few or no words
- **By 24 months**
  - Very few or no meaningful, two-word phrases (not including imitating or repeating)

https://www.autismspeaks.org/signs-autism

Red Flags for Autism/Atypical Development (From Autism Speaks)

At any age:

- Loss of previously acquired speech, babbling or social skills
- Avoidance of eye contact
- Persistent preference for solitude
- Difficulty understanding other people's feelings
- Delayed language development
- Persistent repetition of words or phrases (echolalia)
- Resistance to minor changes in routine or surroundings
- Restricted interests
- Repetitive behaviors (flapping, rocking, spinning, etc.)
- Unusual and intense reactions to sounds, smells, tastes, textures, lights and/or colors

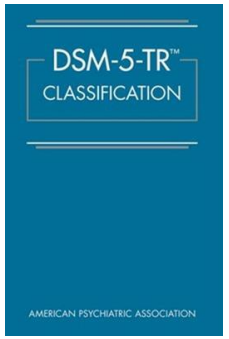
https://www.autismspeaks.org/signs-autism

Overview of Intellectual Developmental Disorder (IDD)

- Deficits in **intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgement, academic learning, and learning from experience**
  - Confirmed by both clinical assessment and individualized, standardized intelligence testing

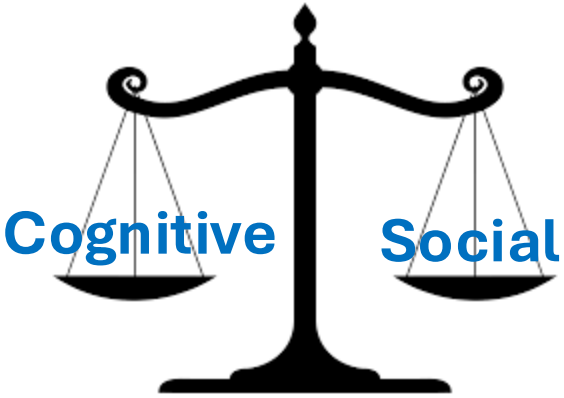
- Deficits in **adaptive functioning** that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility.
  - Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community

*Diagnosed on a continuum of symptom severity



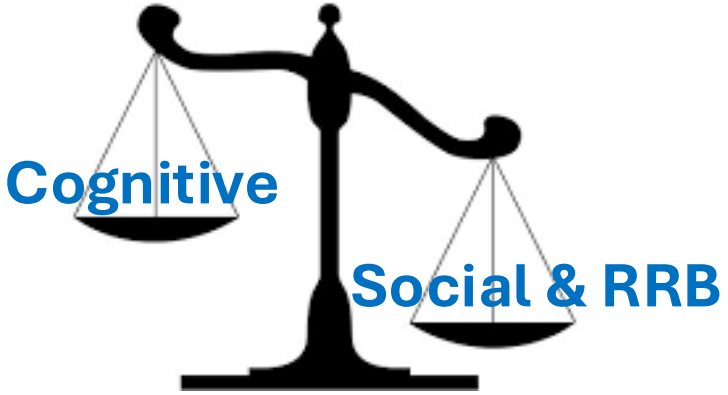
Differences Between IDD and ASD

- **Intellectual Disability**



Social ability as expected based on developmental level

Autism Spectrum Disorder



Social ability less than predicted by developmental level, plus RRB

What May Constitute a Trauma?

- Physical, sexual, or psychological abuse and neglect (including trafficking)
- Natural and technological disasters
- Family or community violence
- Terrorism, mass violence, and school shootings
- Discrimination, prejudice, and racism
- Sudden or violent loss of a loved one
- Substance use disorder (personal or familial)
- Traumatic separation (including as part of an immigration journey or incarceration)
- Refugee and war experiences (including torture)
- Serious accidents or life-threatening illness or events
- Military family-related stressors (e.g., deployment, parental loss or injury)

* The National Child Traumatic Stress Network

Autism and Trauma

- Maltreatment may lead to the development of ASD-like symptoms
  - Social isolation, family stress
  - Poor communication skills, language disorders
  - Socially inappropriate, socially naïve
  - Increased interactions with the legal system/law enforcement
  - Poor emotional regulation
  - Poor coping skills
  - Rigidity/poor flexibility to adversity

Autism and Trauma

- Children with ASD may be more likely to experience trauma
- Co-occurrence
  - 32% in adults with ASD (4% in typical adults)[1]
- Similarities:
  - Rumination
  - Emotional regulation
  - Avoidance
- Also consider attachment disorders

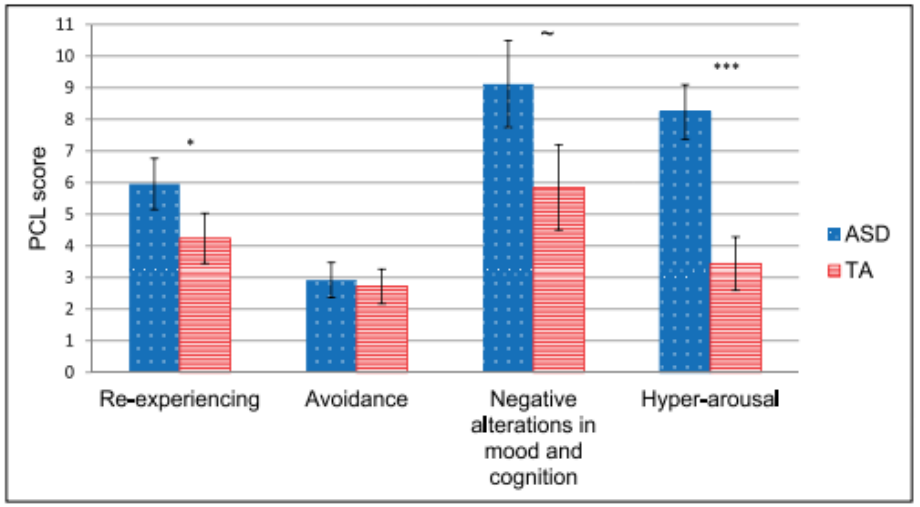
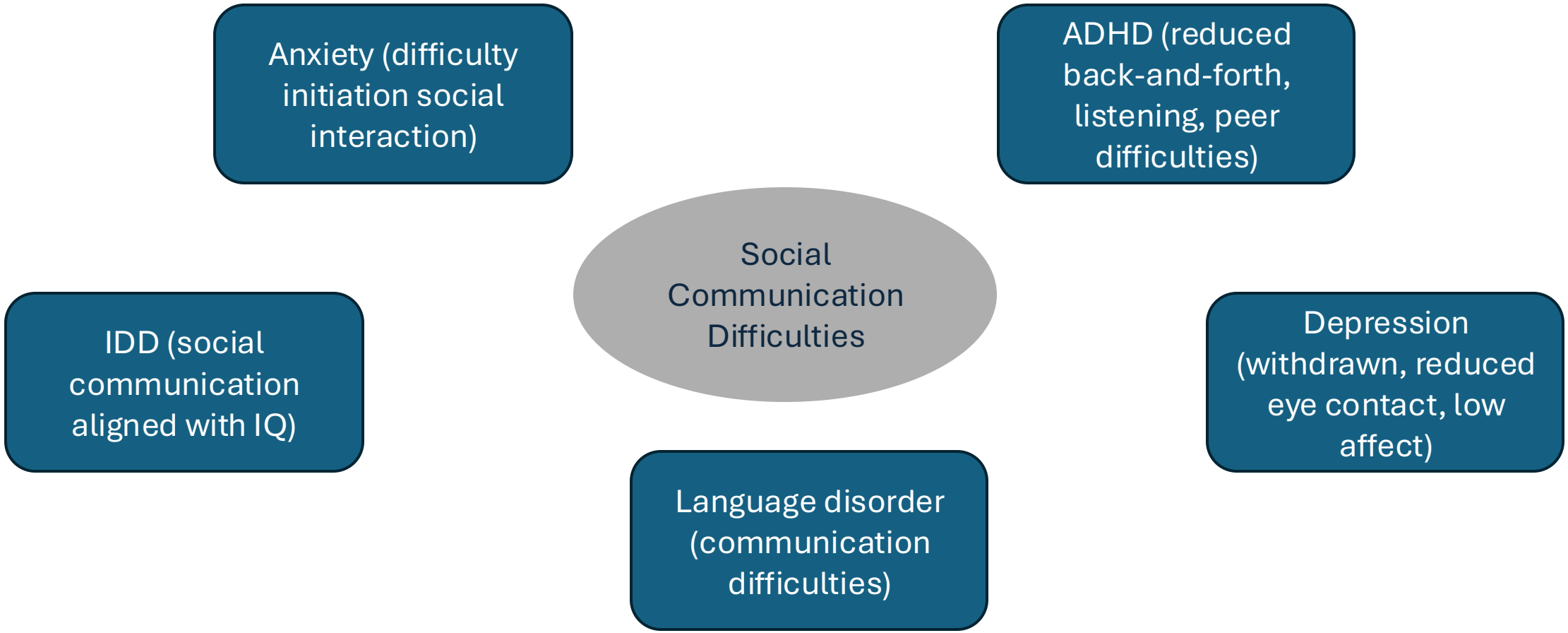


Figure 1. Groups differences in PTSD symptoms.
PCL: PTSD Checklist for *DSM*-5.
~$p = 0.063$, *$p < 0.05$, ***$p < 0.001$.

1. Haruvi-Lamdan et al., 2020)

Differential Diagnosis is Tricky



Differential Diagnosis is Tricky

ADHD (hyperactivity, focused interests, sensory)

Anxiety (repetitive behaviors – picking nails, bouncing foot, rocking)

Restricted and Repetitive Behaviors

Tic disorder/Tourette's (repetitive/stereotyped motor and/or vocalizations)

IDD (repetitive behaviors – rocking)

*Terrible/difficult behavior alone is not sufficient for a diagnosis of a mental health disorder

Screening vs. evaluation

SCREENING

- What?
  - A **brief** and broad tool to help identify potential concerns/risks early on (e.g., developmental, mental health)
- Who?
  - Various healthcare providers, early childhood professionals, schools
- Possible Outcomes?
  - Facilitate timely intervention/supports*
  - Not a diagnosis, serve as starting point if further evaluation is needed (many false positives)

EVALUATION

- What?
  - In depth, can be more comprehensive or specific to determine nature and extent of difficulties
- Who?
  - Various healthcare/educational providers based on expertise and training
- Possible Outcomes?
  - May result in a diagnosis
  - Understand individual's profile of strengths and weaknesses
  - Inform interventions, services, supports*

*some difficulties do not require an evaluation to access services

Best Practices for Evaluation

- Professional training and qualifications
  - Know your limitations and consult
- Evaluation
  - Interview
  - Measures (self-report and caregiver-report)
  - Observation
- Measures/Tools
  - Reliability and validity (none are 100%)
  - Limitations and fit with the individual

Children's Mercy
KANSAS CITY

By: Tiffany Nay, MSW, LCSW, LSCSW
Child and Family Therapist

Training Section 2:

- Common behaviors and behavioral challenges associated with ASD

Common Characteristics in Autism Spectrum Disorder

REPETITIVE BEHAVIORS

Verbal, physical, visual, auditory, etc

SELECTIVE EATING

Brand specific, texture, color, solid/liquid

SENSORY PREFERENCES/ AVOIDANCES

Loud sounds, strong smells, busy places, bare feet, clothing textures, no clothes

ATYPICAL LANGUAGE DEVELOPMENT

Echolalia, GLP, early talker, advanced communication

DIFFICULTY TRANSITIONING

New things or moving to new tasks is very difficult

Common Characteristics in Autism Spectrum Disorder

INSISTENCE ON SAMENESS

Preferring the same clothing, cup, routine, person

DIFFICULTY WITH SELF REGULATION

May “self harm” or impulsively hit, grab, throw things, etc

BODY POSTURING/ MOVEMENTS

Moving their body in a certain way, fingers, hands, etc

LIMITED EYE CONTACT/ RESPONSE TO NAME

Sometimes can question their ability to hear or understand

CARRYING “THINGS”

Keeping certain items with them at all times

Autism requires a different type of teaching

- **Auditory Processing** takes place in the temporal lobe of the brain (2nd largest of the 4 lobes)
  - Ability to listen to spoken language and do something with that information as well as retain it in the memory
- **Visual processing** takes place in the occipital lobe of the brain (smallest of the 4 lobes)
  - Using vision to process information such as through pictures or visual representations of what is being said

Auditory vs Visual Cues or Both?

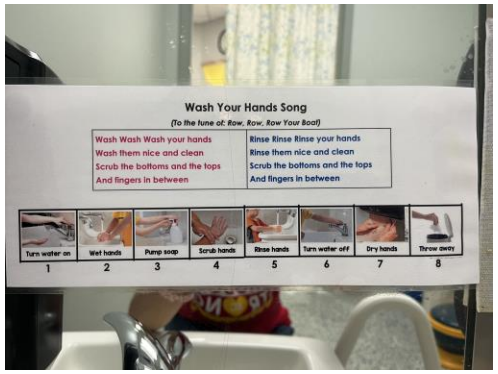
Auditory

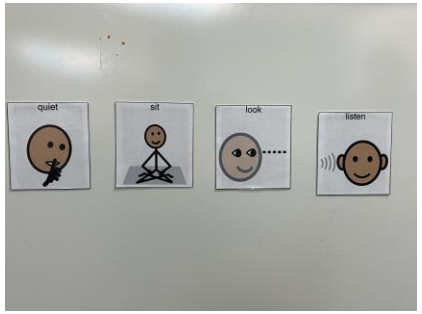
- Timer that can be heard to change activities
- Using songs for transitions to daily routines (clean up song, teeth brushing song, wake up song)

Visual

- Timer that can be seen to change activities
- Pictures or words that indicate order of events, expectations, or choices
- Modeling through your own behavior what the expectation is
- Gesturing to help clarify what is being referenced in instructions

“Visual” examples





Day to Day Prevention is Key

- Controlling the environment
- Small doses of people/places
- Consider order of events
- Responding early to their signs of discomfort/distress
- Using language that tells them what to do instead of what not to do (“you can sit on the couch or jump on the floor”)
- Consider who will be there/where you are going
- Ignoring behaviors that can be ignored (think safety first)
- Prompts (visuals, gestures, modeling, simple verbal prompts)

Sensory Planning

Provide input throughout the day (sometimes you'll hear "sensory diet"), not just when you see they "need" it

Consider clothing preferences ("adaptive" clothing lines)-soft textures, tagless, easy to take on/off for independence

Preferences for tight "input" or avoidant to touch (and being respectful of such)

Barefeet vs shoes/socks (not a hill to die on)

Keep a bag or basket (easily transported) with sensory fidgets or items (noise canceling head phones, chewys, visual items, sunglasses, hats, texture varieties, lap buddy, weighted blanket, etc)

"safe place" in the home: hanging chair, behind a couch, under a table, away from stimuli and provides boundaries around that feel "safe"

Book Recommendation: The Out of Sync Child & The Out of Sync Child Has Fun

Ask specifics about the child's (known) needs during placement finding

Is the child receiving services at school or privately? How will that look to continue providing those services to the child in my home?

Is my home conducive to meeting the varying needs of this child? Other children with high needs, volume of the home, safety factors to consider, etc

Is my family flexible in our routines and expectations? Do we have a "tight" schedule or very busy that could make it hard to be flexible?

Have some solutions and ideas to address the needs being presented at the time

Resource/Book Recommendations

1. The Out of Sync Child
2. The Out of Synch Child Has Fun
3. Forever Boy
4. Ten Things Every Child with Autism Wishes You Knew
5. Uniquely Human
6. The Reason I Jump
7. An Early Start for Your Child with Autism (DENVER model)
8. All My Stripes (children's book)
9. Sesame Street website (Julia)
10. Pattern Seekers

Knights of Columbus Developmental Center

SSM Health Cardinal Glennon Children's Hospital

Through our exceptional health care services, we reveal the healing presence of God.

By:
Dr. Alexandra Vohs, PsyD, Psychologist &
Dr. Katharyn Turner, DO-Developmental Pediatrician

Training Section 3:

- Psychotropic Medications- supports & limitations
- Clinical Interventions

ASD and Medication

When to consider medication management:

Aggression, baseline irritability and/or self-harm causing severe impairment

There are no medications that treat the core symptoms of ASD.

Common medications: 2nd generation antipsychotics

Risperdal/Risperidone

Abilify/Aripiprazole

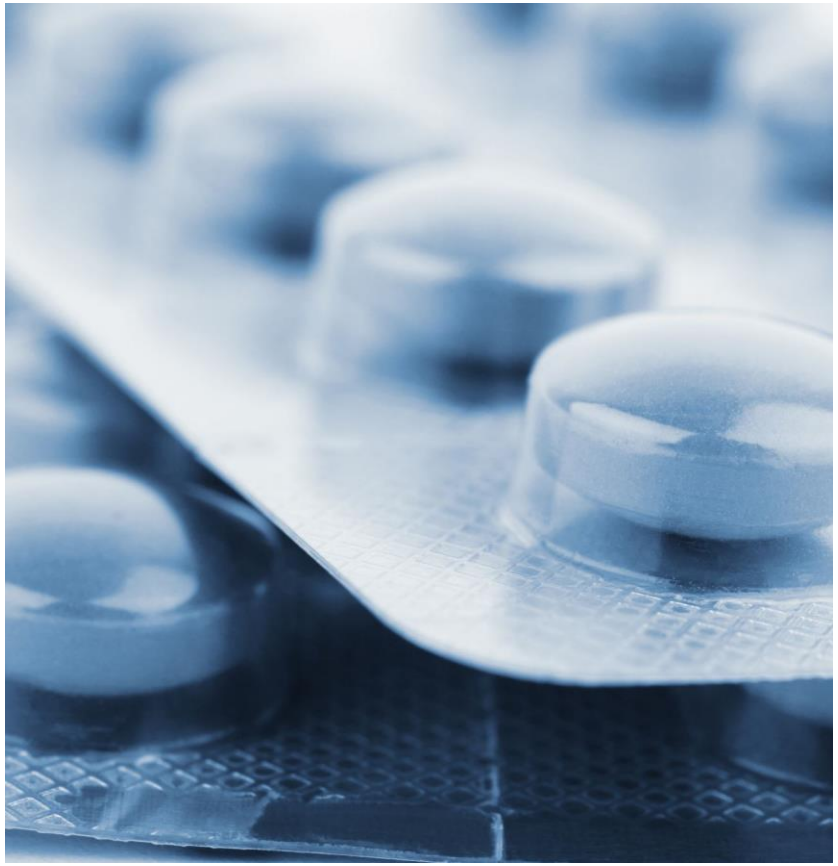
Some of the potential side effects:

Weight gain, sedation, tremors and movement disorders

ASD and Medication

Questions to consider:

- Are you having any difficulty gaining approval for the medication?
- Are you seeing positive changes?
- What side effects have been seen?
- What is the current dose and when was the last dose change?
- How often are follow-ups?
- How is therapy going?
- How is sleep and appetite?
- What supports are in place at school?
- Are there other medications that are being considered?
- Do you feel safe in your home?



ASD and Medication

Additional labs:

- Baseline labs and then every 6-12 months
- Generally includes fasting CBC, CMP, Lipid Panel, Hemoglobin A1C

Follow-up visits:

- Typically every 1-3 months, AIMS exam

Autism Spectrum Disorder Supports

Supports:

- ABA Therapy
- Behavioral Therapy
- Social Skills Groups
- Early Intervention
- IEP or 504 Plan
- Speech-Language Therapy
- Occupational Therapy

ASD with Anxiety or Depression

- When to consider medication management:
  - After formal evaluation, typically also includes questionnaires, meeting DSM-5 criteria

- Common medications:
  - SSRIs
    - Prozac/Fluoxetine
    - Zoloft/Sertraline
    - Lexapro/Escitalopram
  - Histamine H1 antagonist
    - Atarax/Hydroxyzine

- Some of the potential side effects:
  - SSRIs: Nausea, headaches, dry mouth, drowsiness, insomnia, loss of appetite, sexual dysfunction
  - Hydroxyzine: nausea, headache, dry mouth, drowsiness

- Additional labs:
  - May obtain baseline labs such as CBC, CMP, thyroid, iron in initial evaluation
  - Typically no routine labs needed

- Follow-up visits:
  - Typically every 1-3 months

ASD with Anxiety or Depression

Questions to consider:

- Are you having any difficulty gaining approval for the medication?
- Are you seeing positive changes?
- What side effects have been seen?
- What is the current dose and when was the last dose change?
- How often are follow-ups?
- How is therapy going?
- What supports are in place at school?
- How is sleep and appetite?
- Are there other medications that are being considered?
- Does the child have suicidal ideations?
- Have they needed ED visits or hospitalizations?
- Do you feel safe in your home?

Autism Spectrum Disorder with Anxiety or Depression Supports

Supports

- Cognitive Behavior Therapy (CBT)
- Trauma-Focused Cognitive Behavior Therapy (TF-CBT)
- IEP or 504 Plan

ASD with ADHD

When to consider medication management:

- After formal evaluation, also includes questionnaires from two environments, meeting DSM-5 criteria

Common medications:

- Stimulants
  - Methylphenidate/ Ritalin, Quillivant XR, Concerta
  - Dexmethylphenidate/ Focalin
  - Dextroamphetamine/amphetamine/ Adderall
  - Lisdexamphetamine/ Vyvanse
- Non-stimulants
  - Guanfacine, Clonidine/ Tenex, Intuniv
  - Atomoxetine/ Straterra

ASD with ADHD

Potential side effects:

- Stimulants: decrease appetite, headache, nausea, insomnia, anxiety, tachycardia
- Guanfacine, Clonidine: dry mouth, nausea, headache, drowsiness, constipation, hypotension
- Atomoxetine: dry mouth, headache, nausea, fatigue, constipation, erectile dysfunction

Additional labs:

- May obtain baseline labs such as CBC, CMP, thyroid, iron in initial evaluation
- Typically no routine labs needed

Follow-up visits:

- Typically every 1-3 months, weight checks, heart rate and blood pressure checks

ASD with ADHD

Questions to consider:

- Are you having any difficulty gaining approval for the medication?
- Are you seeing positive changes?
- What side effects have been seen?
- What is the current dose and last dose change?
- How often are follow-ups?
- How is therapy going?
- What supports are in place at school?
- Any school suspensions?
- How is sleep and appetite?
- Are there other medications being considered?
- Does the child have suicidal ideations?
- Do you feel safe in your home?

Autism Spectrum Disorder with Attention Deficit Hyperactivity Disorder Supports

- Supports
  - Behavior Therapy
  - Parent Training in Behavior Therapy
    - Parent Child Interaction Therapy (PCIT)
  - IEP or 504 Plan
  - Occupational Therapy

KU LIFE SPAN INSTITUTE
Kansas Center for Autism Research & Training

By:
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Training Section 4:

- Applied Behavioral Analytics(ABA Therapy)

What is ABA? **(Applied Behavior Analysis)**

FOCUSES ON BEHAVIORS OF SOCIAL IMPORTANCE

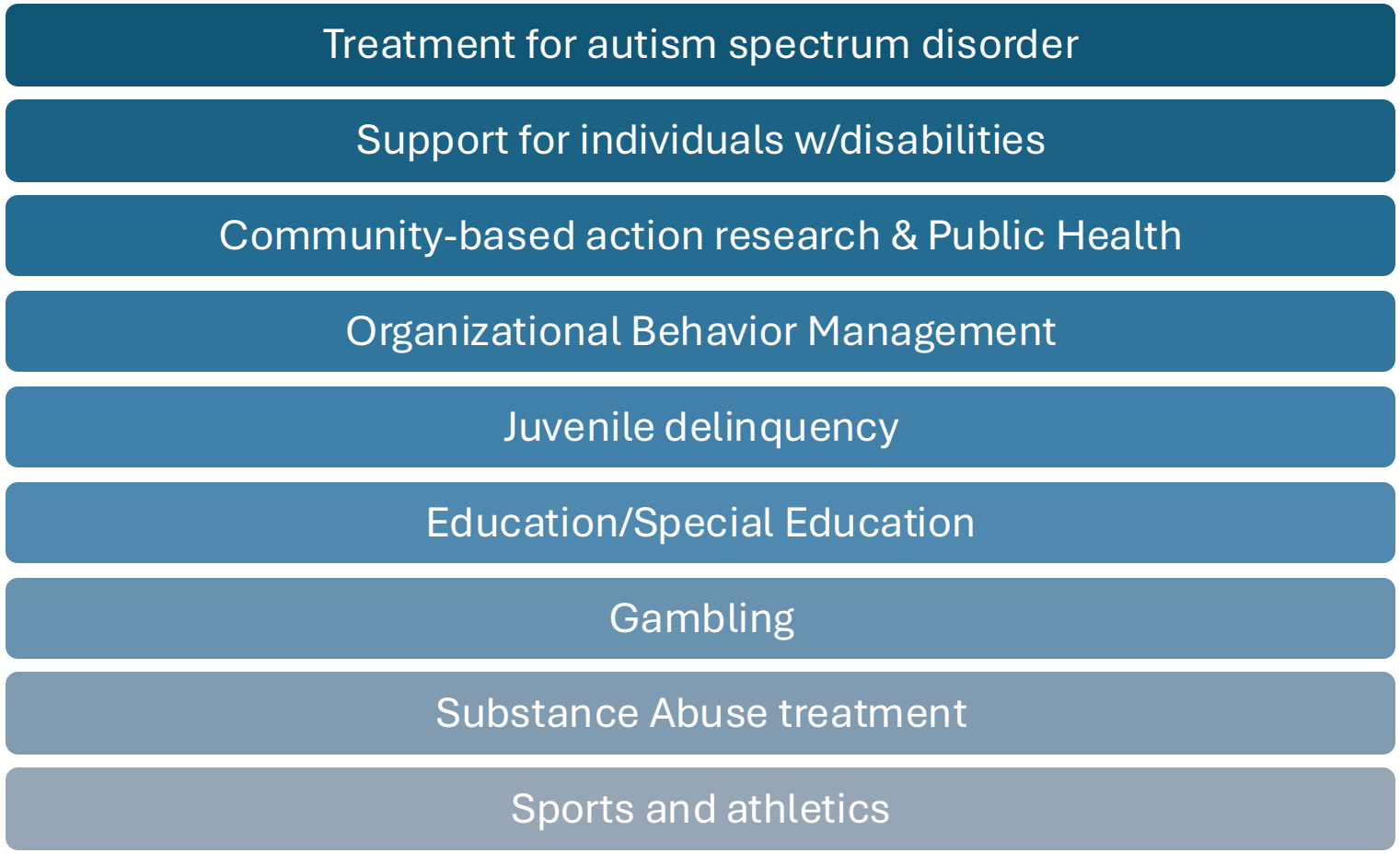
FOCUSES ON MEASURABLE BEHAVIORS

INTERVENTIONS ARE EVIDENCED-BASED AND CLEARLY DESCRIBED

INTERVENTIONS IMPLEMENTED BY PEOPLE IN EVERDAY LIFE

Impact of ABA

- …any field that involves *learning* and *behavior management*
- Range of disciplines and diagnoses



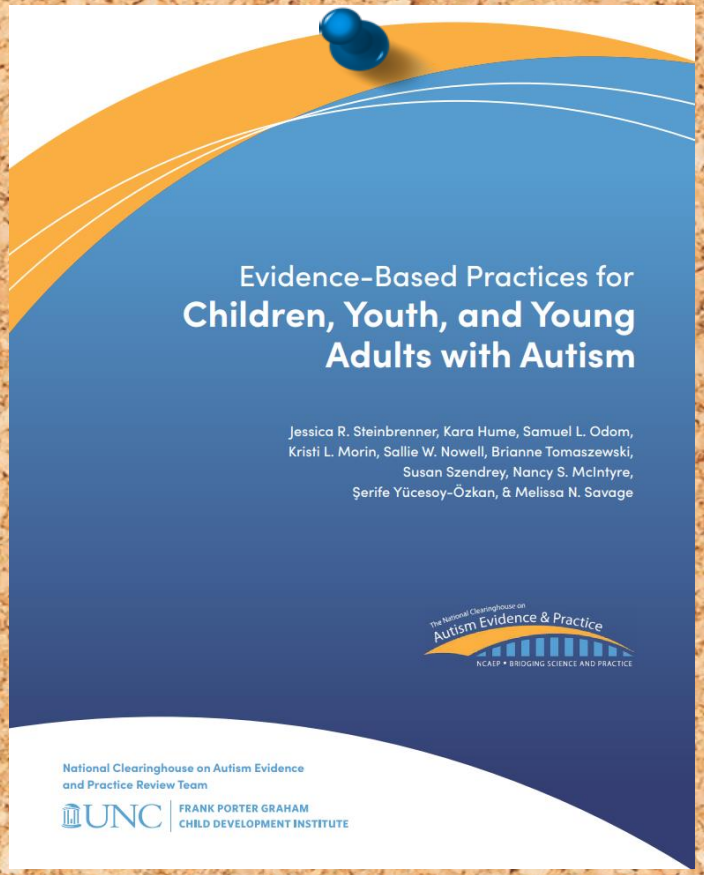
Impact of ABA

- Across the lifespan
- Specific or individualized plan:
  - Goal(s)
  - Behavior(s)
  - Setting(s)

How effective is ABA?

- Countless peer-reviewed studies published demonstrating efficacy of ABA over the past 65 years

How effective is ABA?



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Analysis of the Evidence Base for ABA and EIBI for Autism

Eric V. Larsson, Ph.D., L.P., B.C.B.A.-D. (2012)

OVERVIEW AND SUMMARY OF SCIENTIFIC SUPPORT FOR APPLIED BEHAVIOR ANALYSIS

Authors: Louis P. Hagopian, Samantha L. Hardesty, & Meagan Gregory
The Kennedy Krieger Institute and Johns Hopkins University School of Medicine

Applied Behavior Analysis

Applied behavior analysis (ABA) is a discipline concerned with the application of behavioral science in real-world settings such as clinics, schools, and industry with the aim of improving socially important issues such as behavior problems and learning (Baer, Wolf, & Risley, 1968).

With regard to individuals diagnosed with intellectual and developmental disabilities including autism, ABA-based procedures can be loosely categorized as "**comprehensive**" or "**focused.**" It should be noted that these categories are broad and are mainly distinguished by the goals of treatment. Many children with autism and intellectual disabilities require both types of procedures.

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MEDICAL PROGRESS

Applied Behavior Analysis as Treatment for Autism Spectrum Disorder

Henry S. Roane, PhD[1], Wayne W. Fisher, PhD[2], and James E. Carr, PhD[3]

EDITOR'S NOTE: As the incidence of autism spectrum disorder (ASD) has increased, it has become clear that there is substantial variability of the children affected by this neurodevelopmental disorder. Likewise, there are a wide range of educational and medical therapies for ASD. Early intensive behavioral and developmental interventions, such as applied behavior analysis treatment addressed in this Medical Progress, have shown benefits in some children with ASD. Nonetheless, the increased awareness of ASD and the screening of a wider range of children for ASD have both resulted in an increasingly heterogeneous population of children with ASD. One treatment may not be appropriate for all children diagnosed with ASD. An increasing range of treatment approaches is on the horizon, and these will require rigorous study across the heterogeneous population of children with ASD.

With an increase in the number of children diagnosed with autism spectrum disorder (ASD)[1] to 1 in 68, family demand for insurance coverage of evidence-based treatments for ASD has increased. To date, 43 states have reformed insurance coverage.[2] The majority of the approved statutes explicitly mandate coverage of treatments based on the principles of applied behavior analysis (ABA). In addition, 24 states have now passed legislation to establish professional regulation of ABA providers, known as behavior analysts.[3] The purpose of the present review is to provide information on: (1) basic principles and procedures of ABA treatments; (2) the body of evidence and strength of studies that support the efficacy of ABA treatments; (3) the matching of these procedures to patients with specific characteristics (eg, toddlers) or symptoms (eg, minimal vocal skills); and (4) the assessment of appropriately trained and credentialed behavior analysts.

Given the inclusion of ABA treatments in insurance reform mandates for ASD along with the increasing impact of ASD on the health care system,[4–6] pediatricians should be familiar with the basic principles and procedures of ABA. This knowledge is particularly important in light of research suggesting that physicians report that familiarity with ABA is associated with increased competency for providing primary care to children with ASD.[7] Pediatricians also should be aware that ABA is a field of study and not just a single treatment for ASD. The principles and procedures of ABA have been used to treat a wide variety of socially important problems, such as academic delays and addiction.[8] For the purposes of this discussion, we will delineate between the field of ABA (henceforth ABA) and the application of behavioral principles to the treatment of disorders such as ASD (henceforth ABA treatments). Finally, it should be noted that this review is not intended to be a comprehensive review of ASD treatments or other evidence-based practices for ASD but is instead a primer on the topic.

The core symptoms of ASD include persistent impairments in reciprocal social interaction and communication and restricted and repetitive behaviors. For example, one area of social communication that is particularly problematic in children with ASD is joint attention.

Joint attention involves the shared focus of 2 individuals on a common object or event.[9] Whereas typically developing children will often look at an interesting object, point at it, and then look at their parent to share the experience, children with ASD are much less likely to engage in such forms of joint attention.

Other areas of impairment include difficulties in expressing and interpreting nonverbal communication, poor eye contact, and difficulties in initiating and maintaining relationships. Restricted and repetitive behaviors seen in children with ASD include repetitive motor movements such as hand flapping, restricted use of objects such as lining up toys, and/or stereotypic speech such as echolalia. Interestingly, the majority of children with ASD do not present with intellectual disability.[1] Therefore, manifestations of ASD symptoms vary widely, leading to a clinical heterogeneity of ASD. For example, one child with ASD may have well-developed verbal skills, no intellectual impairment, and relatively mild forms

ABA	Applied behavior analysis
ASD	Autism spectrum disorder
BACB	Behavior Analyst Certification Board
BCBA	Board-Certified Behavior Analyst
DTT	Discrete-trial teaching
EIBI	Early and intensive behavioral intervention
ESDM	Early Start Denver Model
FBA	Functional behavior assessment
NLP	Natural language paradigm
PECS	Picture Exchange Communication System
PRT	Pivotal Response Training
RCT	Randomized clinical trial

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Autism Spectrum Disorder (ASD) & ABA

- Treatment options:
  - Center-based, in-home, schools, etc.
  - Range of hours can vary based on needs
    - Up to 40 hours of 1:1 direct intervention
  - Teaching strategies
    - Naturalistic teaching
    - Discrete Trial Training (DTT)
    - Pivotal Response Training (PRT)
    - Incidental teaching

ASD & ABA in Missouri

- State mandates in place for ASD services
- Medicaid covers ASD services
  - Up to 40 hours of 1:1 services per week
- Typically, a Board Certified Behavior Analyst (BCBA) oversees the case & a Registered Behavior Technician (RBT) provides 1:1 services

Questions and Myths about ABA

#1: Are all ABA programs are the same?

- As with any field, there are better providers & agencies than others
- Ask questions identify service providers to ensure they meet the needs of the child on your caseload

Questions and Myths about ABA

#2: Does ABA make children behave “normally” and remove behaviors that make them unique?

- Providers should include the caregiver and the child into decisions, including goals for treatment
- Treatment often includes reducing behaviors that are dangerous to the child or others around them, or that interfere with learning

Questions and Myths about ABA

#3: Is ABA treatment unnatural and restrictive?

- ABA services occur in a variety of settings (e.g., clinic, home, school), depending on the needs of the child
- For some individuals, this may mean starting in a structured and controlled setting to minimize distractions that interfere with learning
- Minimizing distractions allows for some children to quickly meet success and to see that learning is enjoyable
- The ultimate goal is helping a child learn in their natural environments (e.g., home, school) until ABA services are no longer required.

Is ABA right for you?

- ABA is a behavioral science
- Effective & established treatment for ASD & other populations
- Can be used to increase socially significant skills and decrease behaviors interfering with daily living
- Treatment plans should be individualized & based on assessments
- Can be applied to various settings (e.g., home, school)
- Caregivers are essential team members!
- Important to know goals & service preferences

How to access ABA services?

- Likely need an ASD diagnosis for insurance/Medicaid coverage
- Locate ABA providers near you & inquire about:
  - Ages they serve
  - Insurance they accept
  - Waitlist
    - Getting added
    - How long is their waitlist/time until they can provide services?
  - Necessary intake documentation

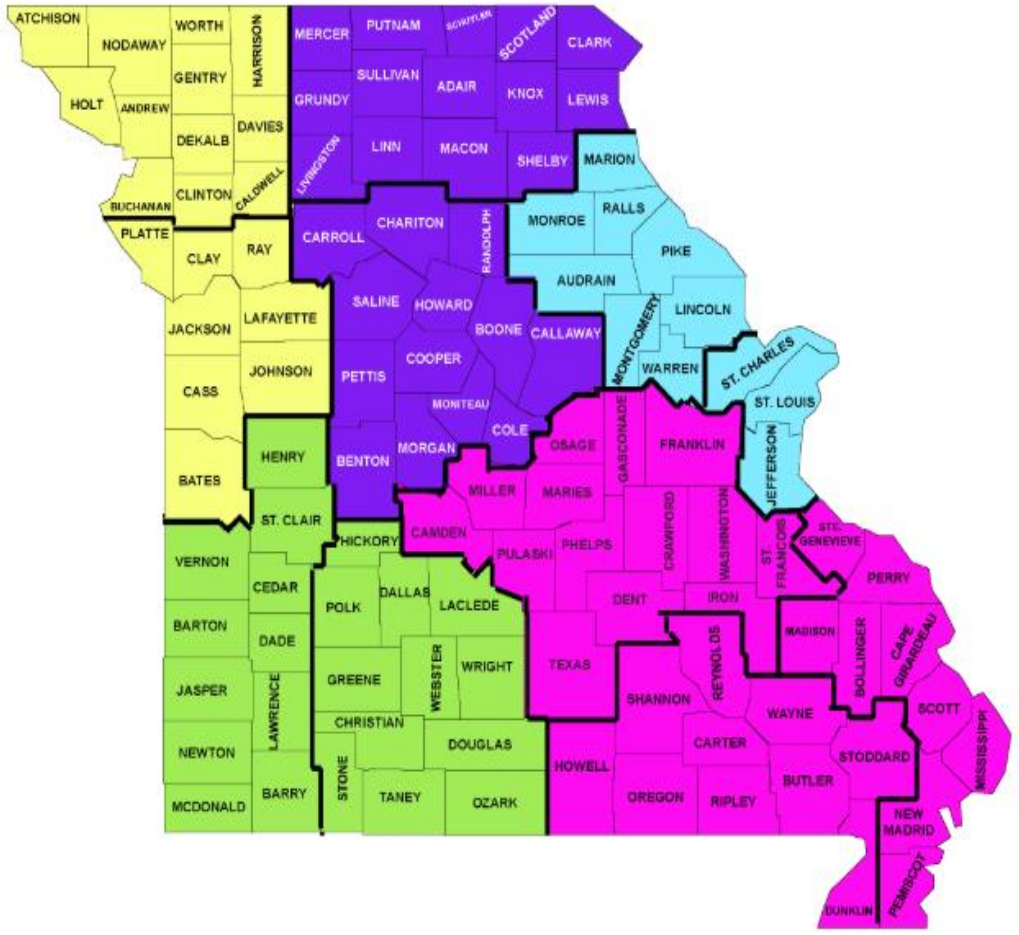
By:
Amber Stockreef, M.Ed., BCBA, LBA

Training Section 5:

- Regional Office and county-wide contracted service providers
- SB 40
- PT/OT
- Engaging Mental health and other community based supports
- Group Services
- Legal/medical guardianship for CD youth over the age of 18
- Other

DD Regional Office

- Place to start for services offered by the state for individuals with intellectual/developmental disabilities
- **12** DD Regional Offices
- Determine eligibility for division services
- Find local Regional Office see, Map of Regional Offices | dmh.mo.gov



Physical Therapy And Occupational Therapy

- Benefits: Improve motor, social and self-care skills. Children with ASD OT/PT can help to manage sensory issues and express emotions.

- Funding:
  - Schools (Individual Education Plan)
  - Medicaid
  - DD Waiver-All except MOCDD
  - Autism Project Funds

Engaging Mental Health Providers

Certified Behavioral Health Centers (CCBHCs)	• Statewide • Open Access • Accept Referrals and Walk-Ins
Youth Behavioral Health Liaisons	• Statewide • Accept referrals from schools, law enforcement, juvenile officers, and other youth-serving agencies
Crisis Services	• Full continuum of crisis services is open to everyone. • They do no have to be engaged in services prior.

Group Services (DD and DBH)

- Group-based services to teach
  - Social Skills
  - Social Language
  - Applied Behavior Analysis
  - Vocational Skills
  - Life Skills
  - Sibling Groups
- Funding
  - DD Autism Project
  - DD Waiver
  - Medicaid
  - Private Insurance

- Psychosocial rehabilitative services (PSR)
  - Goal-oriented and rehabilitative services provided in a group setting to improve or maintain the child's ability to function as independently as possible with their family or community.

Training Section 6:

- Grooming and hygiene
- Toilet training
- Factors that contribute to placement disruption
- Caregiver Perspective

By:
Karen Martin-Director of Comprehensive Systems Navigation

Factors that Contribute to Placement Disruption

It is crucial for professionals to recognize and understand the profound impact that grooming, toileting, communication, and self-care have on a parent's overall well-being and their ability to provide consistent care.

When parents do not feel adequately supported in these fundamental areas, it can significantly strain their ability to cope, leading to increased stress and potential placement disruption.

Professionals should consider not only the practical needs but also the emotional and psychological toll these tasks can have on a parent.

Factors contributing to placement disruption: Caregiver Perspectives

Limited capacity for independence related to the following:

Toileting Resistance

Hygiene

Communicating

Accessing appropriate supports/services

Caretaker fatigue/Self-Care

Considerations include:

The emotional and physical exhaustion that can arise when parents lack the necessary support in daily caregiving tasks, potentially leading to burnout.

The importance of personalized support, recognizing that each family's needs are unique and may require tailored interventions.

The long-term impact of not addressing these basic caregiving challenges, including potential feelings of isolation or inadequacy among parents.

The need for accessible resources and training to empower parents with the skills and confidence they need to navigate these daily tasks without feeling overwhelmed.

Open communication between professionals and parents, fostering an environment of trust and collaboration to prevent misunderstandings and ensure that both the child and parent are receiving the appropriate care and attention.

Hygiene

- Break down complex tasks into smaller steps.
- Teach the steps one at a time.
- Create a checklist for each part of the day.
- Create books that show each step in a routine.
- Use images or words to represent the steps.
- Reward Successes
- Consider whether a structured or natural approach is best.
- Consider whether to teach forwards or backwards.

Toilet Training

OBSERVATION

Routine

OUTLINE YOUR STRATEGY

Success

CONSISTENCY

Ensure everyone working with your child starts training at the same time.

ASSIST

Send in equipment/change of clothing

MODEL

Visual Schedules should be utilized in all spaces as well.

Potty Time=Preferred Time

- Avoid Delaying Underwear Training
- Stay Calm don’t Fuss Over Accidents
- Use Rewards to Build Confidence and Reassurance.
- Empower Your Child to Communicate Their Needs.
- Use visual aids.
  - Visual Schedules.
- Make the Event, Eventful.
- Incorporate Music, Singing, Dancing to Promote Comfort.
- Accepting Humility to Promote Calm and Relaxation
  - Children enjoy watching their parent be funny on purpose.

Communication about Hygiene and Toileting

- Be patient
- Slow down when speaking
- Give your child time to process what you have said.
- Repeat key words.
- Use Visual Supports
- Incorporate pictures, symbols, gestures, and objects that support what you're saying.
- Incorporate tools for Understanding
- Use pictures, timetables, drawings, or cue cards.
- Use Sign Language.

- Engage through music
- Sing Songs
- Celebrate, Reward and Praise.
- Step Outside Your Comfort Zone
- Collaborate with Professionals and other parents

- WHEN IN DOUBT SEEK OTHERS OUT

Accessing Incontinent Supplies

Justification: a healthcare professional must determine that diapers are medically necessary.

Prescription must be obtained by the prescribing physician

Supportive documentation must be secured and submitted in efforts to further justify the need.

The prescribing physician/representative can coordinate/mediate the process with Medicaid and identified vender

***This process is applicable when attempting to secure relevant services fund by Medicaid:

Accessing and Securing Incontinent Supplies/Services continued:

WHO CAN PAY FOR IT

- Home State 855-373-4636
- Show Me Healthy Kids 877-236-1020
- Funding through St. Louis Regional Office
- Private Insurance

VENDERS

- eSpecial Needs
- AdaptHealth
- Adapt-Ability Inc.

Self-Care

TAKE BREAKS

Self-Compassion

EATING/SLEEPING

It's okay not to be okay

ASKS FOR HELP TEACHING THEM

Acknowledging that you don't know how, is half the battle--- The First step toward growth and progress

SUPPORT GROUP

Steal Time on purpose

DELEGATING RESPONSIBILITIES

Seek Professional help.

Final Closing Thoughts

Thank you!

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