ECHO Notes:

Dr. Siegel's Presentation

- Medication management options with ASD
    - Case example: 14yo boy w ASD, minimally verbal. Began hitting self in check two months after moving to new school – increasing in intensity. Occurs during transitions and with school demands. Started Keppra due to seizure, and recently became older brother. How do you conceptualize hitting behavior?
        - Psychiatric co-occurring d/o: could it be anxiety?
        - Behavioral function & reinforcement: obtain social attention or internal stimuli?
        - Is hitting a side effect of meds?
        - Is hitting related to communication system not being used at school?
        - Is he seeking sensory pressure?
        - Demand: ability match? Is work in classroom too hard/easy?
        - Is there possibly tooth decay?
        - Is it related to family changes at home?
    - Irritability is a common pathway symptom
        - Self injury is not a diagnosis it is a symptom
    - ASD has common comorbidities with other psych diagnoses:
        - Phobia/OCD, social anxiety, GAD, etc
    - Diagnosing psychiatric co-occurring D/o's in people with ASD
        - Questions to ask:
            - Is this behavior/symptom typical of ASD?
            - Is it appropriate to developmental level?
            - Does it serve and adaptive function?
            - What is the environmental relationship to the symptom?
    - Medications and ASD
        - No medications address core features of ASD
        - Medications are used for:
            - Psychiatric and co-occurring d/o's
            - Targeted behavioral symptoms (like irritability)
        - All medications discussed are off-label use except for risperidone and aripiprazole for irritability in ASD (5-17yo)
    - Common medication targets
        - Psych
            - Anxiety
            - ADHD
            - Mood d/o
            - Sleep d/o
            - Catatonia
        - Behaviors:
            - Self injury
            - Aggression
            - tantrums

Evidence in ASD for medications

- Stimulants: Ritalin with 1 large RCT (random control trial)
- Alpha 2 agonist: Guanfacine: 1 large positive, 2 small positive
- SNRI: Strattera
- SSRIs: Fluoxetine Lexapro, Zoloft
    - No studies for depression or anxiety, 1 RTC for repetitive behavior
- Tri-cyclic: Anafranil

- Approaches to Avoid:
    - Evidence of harm/no effects for ASD
        - Chelation – no evidence and 2 deaths documented of children with ASD
        - Secretin – no benefit
        - Stem cell procedure – no evidence
        - Hyperbaric oxygen treatment 0 no evidence
        - Gluten free/casein free diet – no effect on behavior after 6 randomized control trials
- What to do in practice (moving from evidence to opinion – Dr. Siegel's application of the evidence)
    - Anxiety
        - CBT for those with capacity
        - Strong evidence in non-ASD kids: listed in order of evidence and line of defense
            - Sertraline
            - Lexapro
            - Fluoxetine
            - Intuniv
        - Not as much evidence for, last line of defense
            - Buspirone
            - Venlafaxine
    - ADHD
        - Strong evidence in non-ASD kids: listed in order of evidence and line of defense
            - Methylphenidate
            - Adderall, Vyvanse
            - Guanfacine/clonidine
            - Atomoxetine (inattention)
        - Not as much evidence for, last line of defense
            - Amantadine
            - Atypical Anti-psychotics
    - Depression
        - Psychotherapy for those with capacity
            - SSRI's
    - Insomnia
        - Sleep hygiene
        - Resolve enuresis

        - Melatonin 3mg
    - Not as much evidence for, last line of defense
        - Clonidine
        - Mirtazapine
        - Trazodone (resistant to sleep, or middle of night awakenings)
    - Mood d/o or Mania
        - Depakote
        - Lithium
        - Lamictal
    - Repetitive behavior (consider if it is actually needing treatment)
        - Risperidone
        - Aripiprazole
    - Serious behaviors (aggression, SIB, tantrums)
        - If no other diagnoses makes more sense
            - Then turn to guanfacine XR (more helpful in smaller and younger kids – not as effective with older/bigger youth)
            - Risperidone
            - Abilify
            - Haldol

Discussion

- Can you comment on psychotherapy (play therapy maybe?) for toddlers with anxiety (and ASD) - ie- how well do kids respond to this while considering adding medications?
    - CBT is the gold standard as opposed to play therapy
    - For younger kids: could consider an SSRI for kids too young for CBT if absolutely needed
        - At that point it could be considered to work more with parents on working on regulation skills and parental regulation skills
- Is there evidence to support the use of weighted blankets for emotional regulation for sensory seeking younger children/toddlers?
    - The challenge is that it is very child dependent. Typically, I will refer to OT because OT can help sort out what sensory strategies will work for individual families.
    - If you are interested in a weighted blanket, definitely work with an OT to find the appropriate size and weight
        - Also, typically OTs will recommend that in a 60 minute timeframe, keeping the weight on is typically only effective for 20 minutes per hour
- For PCPs doing medication management for a patient with ASD, what is the strategy for tapering off of medications that clients have been on for years and how to you approach parents about starting new medications
    - It can be very challenging, typically I frame it to parents that you are supposed to switch as opposed to add to fully see the effects of the medications
    - Tell them what to expect, talk about how long to wait to see effects of medications, talk about expectations for changes for behaviors, increase frequency of contact/visits to support parents. Remind parents that medications can always be restarted

        - "If we are not sure something is working, it probably isn't" – if medications are not clearly better they may not always be worth it
            - Transparency is key
            - In person visits are the best, avoid being overly reactive
- Any suggestions for ways to formalize input from school personnel who are with these kids a fair amount of the time?
    - Get a communication book that goes between teaches and parents
    - Using scale called CAPS – tracks behavioral responses between morning and afternoon and provides a lot of helpful information
    - kpaul

Resources:

- ASD parent medication guide, find here: Parents' Medication Guides (aacap.org)
- Maine - Attend | Behavior (attendbehavior.com)
        - This is also a great resource for families that have children with Autism that also have MaineCare. This allows the family access to ABA-based coaching methods to curve behavior. DHHS is providing this service for up to 200 kids that have MaineCare and meet certain parameters. It is powered by RUBI which is an evidence-based parent coaching practice for parents of children living with ASD.