SYSTEMS-BASED PRACTICE
DEVELOPMENTAL DISABILITIES SYSTEM

Note: The term “Intellectual Disability” will be used throughout this module, in place of the term “Mental Retardation.”

SYSTEMS-BASED PRACTICE: DEVELOPMENTAL DISABILITIES SYSTEM
OBJECTIVES*

Knowledge
The resident will demonstrate an adequate knowledge of:

1) The configuration of services for persons with developmental disabilities in their home state. (1,2)
2) How to access the local services array for persons with developmental disabilities. (2,10)
3) State-wide and local advocacy organizations for persons with developmental disabilities in their home state. (4,9)
4) The role of the local Developmental Disabilities Service Agency Case Manager within the service delivery system. (5,7,10)
5) Eligibility requirements for their state’s services for persons with a developmental disability. (2,4,5)
6) How to identify and describe the functional limitations that an individual with a developmental disability faces. (2,4)
7) The use of the Individualized Service Plan (ISP) and the Person Centered Planning (PCP) Process in driving service delivery. (1-12)
8) The risks to personal safety related to the developmental level of the child with an intellectual disability and the lack of social awareness of a child with a pervasive developmental disorder. (2,4)
9) The developmental course of pervasive developmental disorders and intellectual disability and the changes in the service array that must occur as a person with a developmental disability ages. (2,4)
10) An understanding of the role of the University Center for Excellence in Developmental Disabilities Education, Research & Service (UCEDD) in their home state. (2,5,10)
11) An understanding of the psychotherapeutic interventions for this age group and for intervention with the child’s family. (1-4)
12) An understanding of the standards of care for psychopharmacological interventions for this age group. (1-4)
13) An understanding of the principles of cognitive/behavioral interventions for this age group. (1-4)
14) An understanding of the complementary and alternative medicine approaches to the treatment of pervasive developmental disorders. (2,5,10,11)
15) Child and adolescent psychiatrist’s role in working with developmental disabilities services and individual youth/families regarding their developmental needs. (1-12)

* Parentheses refer to systems-based practice competencies in the RRC Program Requirements. See Appendix 1 for complete list of competencies.

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Skills
The resident will demonstrate the ability to:
1) Complete a diagnostic assessment of an individual suspected of having a developmental disability. (7,8)
2) Identify and treat comorbid psychiatric and medical conditions in a person with a pervasive developmental disorder or intellectual disability. (7,8)
3) Coordinate care with the child’s primary care physician and attending medical specialists. (5,7,10)
4) Assist the family of a child with a developmental disability in identifying needed state services. (1,2,4,5-12)
5) Assist the family of a child with a developmental disability through the application and eligibility process for state services. (2,4,5)
6) Coordinate care with a Developmental Disabilities Service Agency Case Manager. (1,2,4-11)
7) Provide needed medical expertise to the PCP process or other interagency planning process such as a Child and Family Team. (1-11)
8) Provide the needed expertise to adjust the ISP as the individual with a developmental disability ages. (1-11)
9) Identify the needed level of supervision to achieve safety for a child with a developmental disability. (1,2,4-6,9-11)
10) Advocate for the child with a developmental disability and their family in order to obtain needed services. (1,2,4-10)
11) Advocate with other medical professionals for treatment of comorbid psychiatric and medical conditions. (1,2,4-11)
12) Access the technical assistance available to practitioners through their state’s UCEDD. (1,2,4,7-11)

Attitude
The resident will demonstrate the commitment to:
1) Provide to state agencies the needed documentation to support the child’s eligibility for developmental disabilities services. (1,2,4,5,7-9)
2) Coordinate care with other medical professionals in order to better serve a child or adolescent with a developmental disability. (1,2,4-11)
3) Avoid “diagnostic overshadowing” (the tendency to attribute medical and psychiatric symptoms to the person's intellectual or developmental disability). (1,2,4-12)
4) Partner with the family of a child with a developmental disability when they are denied access to needed services due to stigma related to their condition. (1,2,4-12)
5) Partner with families and Case Managers for optimal service delivery. (1,2,4-11)
6) Participate in the PCP Process or Child and Family Team. (1-11)
7) See advocacy as an integral part of the work with a child with a developmental disability and their family. (1,2,4-11)
8) Seek out technical assistance from their state’s UCEDD and other local sources of expertise in order to better serve the child with a developmental disability and their family. (1,2,4-11)
9) Provide guidance to families who wish to consider the use of CAM for their child with a developmental disability. (1,2,4-12)
10) Help families with children with developmental disabilities “navigate the system.” (1-11)
OVERVIEW

This module will provide an introduction to “navigating the system” of services for children and adolescents with a developmental disability. Across the country, there are many different configurations of state-sponsored services that, at times, are a barrier to the identification of the appropriate service agency for a needed service. There are also significant variations in eligibility requirements which also can create a barrier for families seeking care for their child with autism or an intellectual disability.

There are many unique aspects to service planning and delivery in the developmental disability field. The Person Centered Planning (PCP) process is unique to the field of developmental disabilities as a method for futures planning. The child with a developmental disability often requires the coordination of multiple services from a variety of community providers plus needed specialty care from multiple medical providers. As the incidence of mental health conditions is higher for the population with a developmental disability than the typically developing population, the correct diagnosis of co-occurring conditions is essential. The practitioner must ensure that symptoms of a co-occurring psychiatric disorder are not mistaken for behavior due to their developmental disability. The child with a developmental disability is more likely to have a co-occurring or causative genetic or neurological disorder that contributes to their presentation. For many reasons, families of children with developmental disabilities often consider the use of complementary and alternative medicine (CAM) treatment when other treatments do not result in the hoped-for response.

I. LOCAL AND STATE ORGANIZATIONAL STRUCTURES FOR SERVICES FOR CHILDREN AND ADOLESCENTS WITH DEVELOPMENTAL DISABILITIES

There is significant variation from state to state in the organization of services for persons with developmental disabilities. In many states, services for persons with developmental disabilities are provided by the same agency responsible for public mental health services; for example, in Michigan, the Department of Community Health is responsible for services for persons with developmental disabilities as well as mental health and public health services. However, services for persons with developmental disabilities are not always “housed” in the branch of state government responsible for health-related services; in Arizona, for example, the state’s Division of Developmental Disabilities is part of the Department of Economic Security, which is also home to Child Protective Services and the agencies responsible for juvenile justice.

California provides yet another model for services for the developmentally disabled. The California Department of Developmental Services’ Regional Centers provide many of the services required by a child with developmental disabilities, including assessment and diagnosis, counseling, individualized service planning, genetic counseling, psychiatric services, and management services. In other states, the local case management functions for persons with developmental disabilities are contracted out to a variety of provider agencies, which in turn may contract with other agencies for needed community-based services. The role of the case manager within agencies for the developmentally disabled is similar to those within behavioral health agencies; the Developmental Disabilities Case Manager will usually be the monitor for the
Individualized Service Plan (ISP), “broker” for services, and advocate for the child and family within the system of care.

There is also variation from state to state in the conditions that are covered by disability services. States such as Arizona limit developmental disabilities services to autism, epilepsy, cerebral palsy and intellectual disability, and provide services to persons who are blind and/or deaf through other state agencies while still other disabling conditions, such as Asperger’s Disorder or traumatic brain injury do not have a specific “home” in state government for services. Other states, such as Michigan, more broadly define developmental disabilities and may be more inclusive as to who is able to access services (Michigan Department of Community Health Web site, http://www.michigan.gov/mdch/0,1607,7-132-2941_4868_4897-14626--.00.html).

The Web site for the National Association of State Directors of Developmental Disabilities Services (NASDDS) has an index of all state programs for persons with developmental disabilities which may be accessed at: http://www.nasddds.org/MemberAgencies/index.shtml

To be an effective health care provider and advocate for children with developmental disabilities, the child psychiatrist must have a good working knowledge of the organizational structure of services for children with developmental disabilities on the state and local level. The child psychiatrist must be aware of whether the local Case Managers for services for children with developmental disabilities are part of the state government or a local, contracted provider agency.

II. ELIGIBILITY FOR STATE SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

There is also variation from state to state in the requirements for eligibility for services for persons with developmental disabilities. Most require the individual to be eligible for Medicaid (Title XIX) in order to receive services. Others put limitations on the diagnoses that are covered; for example, in Arizona, only persons with autism are eligible for services, persons with the other pervasive developmental disorders are not eligible for services. Several states require that the developmental disability be evident by either age 18 or 21; those, for example, who acquire a traumatic brain injury after age 21 would not be eligible for services. Many states also require documentation of the presence of significant functional limitations in a number of life areas similar to that which is required for the diagnosis of intellectual disability in DSM-IV-TR. Though evidence of significant functional limitations in two of seven life areas is required for the DSM-IV-TR diagnosis of intellectual disability, states such as Arizona require evidence of functional limitations in three life areas for eligibility. In DSM-IV, these life areas are: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work leisure, health and safety.² Instruments such as the Vineland Adaptive Behavior Scales or the Adaptive Behavior Assessment System (ABAS) may be used to determine a child or adolescent’s functional status.
States may also have separate eligibility guidelines for developmental disabilities services and Title XIX Medicaid services. When an individual qualifies for developmental disabilities services, but not for Medicaid, there is typically less access to needed services.

To be an effective health care provider and advocate for children with developmental disabilities, the child psychiatrist must be aware of the eligibility requirements of their state for services and be willing to assist the family in the application process by providing them with the needed documentation of diagnosis and functional limitations.

III. SERVICE TRANSITIONS

There is also variability from state to state in the time of transition from one developmental service to another. Early Intervention Services typically will begin in the first year of life, but the transition to services developmentally appropriate to older children can occur from age three to age six. Eligibility requirements may change with the transition as well; some children who are eligible for Early Intervention Services may not meet the eligibility requirements for services for older children.

There is also a transition from children’s services to adult services; depending on the state, this may occur at either age 18 or 21. It is critical that the need for permanent guardianship be assessed at this transition point. This assessment must be done in a careful and deliberate fashion in order to determine which elements of decision-making an individual will need support for and which elements the individual can manage independently. Different supports will be necessary, for example, for a person with an intellectual disability who is living and working independently versus a person with both a developmental disability and a serious mental illness that is only partially responding to treatment.

To be an effective health care provider and advocate for children with developmental disabilities, the child psychiatrist must be aware of when the transitions in service occur in their state and be willing to provide the needed documentation to ensure continued eligibility. The child psychiatrist must also be willing to provide an individualized assessment of the person’s guardianship needs.

IV. THE SERVICE ARRAY: THE MOVEMENT TOWARDS COMMUNITY-BASED SERVICES

Again, there is variability from state to state in the mix of community-based and residential services available to persons with developmental disabilities. Arizona leads the nation with over 85% of individuals enrolled in services for the developmentally disabled living in community settings either in their own homes or group settings of four individuals or less. In other states, there is more of an equal balance between those living in community-based settings and Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

Most states show a trend toward a significant increase in the money spent on community-based services for the developmentally disabled in contrast to steady or decreasing funding for those in institutional settings. Many states are actively transitioning individuals from institutional settings
or providing an array of community-based services at the time an individual enters into the system. One such effort to provide community-based services is the Individual Options (I/O) Medicaid Waiver. According to the Individual Options Waiver Handbook,³

“Medicaid will allow people to stay in their homes and get support rather than require them to live in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). The I/O Waiver pays for: Homemaker/personal care, Home Modifications and adaptations, Transportation, Respite Care, Social Work, Home-delivered meals…Supported Employment, Day Habilitation…”

The trend toward community-based services for persons with developmental disabilities is supported by Medicaid waivers and other state initiatives to support community-based care.

**To be an effective health care provider and advocate for children with developmental disabilities, the child psychiatrist must be aware of the array of services designed to support the child with a developmental disability in their home and community. The child psychiatrist must be also be aware of the mix of institutional and community-based services in their state and support the family’s choice to keep their child in their home for as long as possible despite severe disabilities.**

**V. THE SERVICE ARRAY: ACCESS TO BEHAVIORAL HEALTH SERVICES**

There is a significant variation from state-to-state in the access for children and adolescents with developmental disabilities. This access is essential due to the higher incidence of behavioral health disorders in persons with developmental disabilities in comparison with the general population.⁴ In state organizational structures where services for the developmentally disabled are provided by the same agency or department that provides the mental health services, access may be less of a concern. Access to behavioral health services in states where the organizational structure for services is different may be guaranteed by contract; for example, in Arizona, the Division of Developmental Disabilities contracts for mental health services for persons with developmental disabilities enrolled with the state’s Division of Behavioral Health Services and its contracted Regional Behavioral Health Authorities. In other states where there is no formal access to mental health services for persons with developmental disabilities, the family or Case Manager must search for any available provider who is willing to provide psychiatric care (personal communication).

*Many child psychiatrists feel ill-equipped to identify the presence of co-occurring mental illnesses in persons with developmental disabilities. As an aid to all practitioners who work with persons with both a mental illness and a developmental disability, the National Association for the Dually Diagnosed (NADD) has developed, in association with the American Psychiatric Association, the Diagnostic Manual – Intellectual Disability (DM-ID): A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability. The DM-ID is intended to be an adaptation of the DSM-IV-TR for persons with an intellectual disability.*⁵

**To be an effective health care provider and advocate for children with developmental disabilities, the child psychiatrist must understand the nature of access to mental health**
services for children and adolescents with developmental disabilities in their state. In states where there is no formal access to mental health services for persons with developmental disabilities, the child psychiatrist should consider providing the needed psychiatric services out of their private office or other community-based setting. The child psychiatrist must also be a strong advocate for access to, and coordination of, services for children and adolescents with developmental disabilities and their families. The child psychiatrist must also advocate for access to the appropriate training for all care providers working with persons with developmental disabilities.

VI. SAFETY ISSUES

Children and adolescents with developmental disabilities are at a higher risk for accidental injury than their typically developing peers. For example, Volkmar and Weisner indicate that children with autism are at an increased risk of injury or death due to drowning or suffocation. Thus, a careful assessment of the child or adolescent’s safety risk must be done at the beginning of treatment and updated regularly as the child develops. Multiple factors must be taken into account in developing the risk assessment for a child or adolescent with a developmental disability. Elspeth Slayter and her associates have identified four factors that increase risk for injury in children with intellectual disabilities.

- Co-occurring medical issues: the poor balance and/or gross motor coordination problems often seen in persons with an intellectual disability may cause a higher rate of accidental injury. Obesity, also associated with increased injury risk, is also more common in persons with an intellectual disability.
- Functional capacity: problems with inattention or impulsivity and limited problem solving skills can lead to an increased risk of accidental injury.
- The higher rate of mental health disorders in persons with intellectual disability also increases risk of accidental injury.
- The higher rate of epilepsy in this population also predisposes them to a higher frequency of accidental injury through falling.

To be an effective health care provider for children with developmental disabilities, the child psychiatrist must be able to complete an accurate and detailed risk assessment.

VII. THE INDIVIDUALIZED SERVICE PLAN (ISP)

Individualized Service Planning is a strengths-based approach that has been used to direct community-based treatment in systems of care for many years. Typically, a team comprised of both professional and community members come together to develop a plan for support of the child or adolescent with a mental illness and their family in their community. Also known as child and family teams or wraparound teams, the planning approach results in a guide for community treatment that is continually updated to meet the changing needs of the individual and their family. Within agencies providing services for persons with developmental disabilities, the focus of the ISP may be slightly different; according to Suzanne Dale Wilcox,

“The Individualized Service Plan is both a design for services as well as the mechanism for linking persons who are mentally retarded with that combination
of services which will enable them to live in the community with a progressively
decreasing number of life-long services.”8

In most cases, the ISP is updated on an annual or semi-annual basis; regular updating of
the ISP is essential in order to meet the child’s changing needs.

To be an effective health care provider and advocate for children with developmental
disabilities, the child psychiatrist must be willing to participate in the individualized
treatment planning process for the children with developmental disabilities in their care.
The child psychiatrist also must be willing to advocate for the services identified by the ISP
process for the child or adolescent and their family.

VIII. PERSON CENTERED PLANNING (PCP)

The Person Centered Planning (PCP) process is a method for future planning for persons with a
developmental disability that is in increasing use across the U.S. The PCP Education Site,
managed by the Cornell University School of Industrial and Labor Relations defines Person
Centered Planning as:

“…a process-oriented approach to empowering people with disability labels. It
focuses on the people and their needs by putting them in charge of defining the
direction for their lives, not on the systems that may or may not be available to
serve them. This ultimately leads to greater inclusion as valued members of both
community and society. Person-centered planning involves the development of a
"toolbox" of methods and resources that enable people with disability labels to
choose their own pathways to success; the planners simply help them to figure out
where they want to go and how best to get there.”9

This approach to future planning is very much in keeping with the self- and family-directed care
initiatives that many states are beginning to use to drive service delivery to persons with
developmental disabilities. It is a powerful tool for self determination, particularly for
adolescents who are aging out of children’s services. In contrast to the ISP, which is usually
more focused on building on current strengths and meeting current needs, the PCP process
focuses on assisting the individual with a developmental disability towards a specific future goal,
such as the wish to live independently.

To be an effective health care provider and advocate for children with developmental
disabilities, the child psychiatrist must be willing to participate in the PCP process for
adolescents with developmental disabilities in their care. The child psychiatrist also must
be willing to advocate for the services chosen by the adolescent and their family during the
PCP process.

IX. THE ROLE OF THE UNIVERSITY CENTERS FOR EXCELLENCE IN
DEVELOPMENTAL DISABILITIES (UCEDD)
Each state has at least one University Center for Excellence in Developmental Disabilities Education Research and Service (UCEDD) that may provide valuable resources to the practitioner working with individuals with developmental disabilities. According to the Association of University Centers on Disabilities:

“These university centers work with people with disabilities and members of their families, state and local government agencies, and community providers in projects that provide training, technical assistance, service, research, and information sharing, with a focus on building the capacity of communities to sustain all their citizens.”

The available services and supports from the UCEDD and their impact on state services for the developmentally disabled may vary from state to state. More information on UCEDD is available at their Web site: www.aucd.org.

To be an effective health care provider and advocate for children with developmental disabilities, the child psychiatrist must be able to identify those services and supports available through his or her state UCEDD. The child psychiatrist must also be willing to seek out technical assistance from the state UCEDD and other sources of expertise on developmental disabilities in order to better serve children and adolescents with developmental disabilities.

X. COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM) AND THE TREATMENT OF A CHILD WITH A DEVELOPMENTAL DISABILITY

Complementary and alternative medicine is defined by the National Institute of Health’s National Center for Complementary and Alternative Medicine as “a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine.” Parents of children with autism spectrum disorders are seeking out CAM treatments such as megavitamin therapy, dietary therapy and chelation for their children in increasing numbers. The reasons for this are many, but may be summed up best by the American Academy of Pediatrics Committee on Children with Disabilities’ statement on “Counseling Families Who Choose Complimentary and Alternative Medicine for their Child with Chronic Illness or Disability”:

“Many parents become frustrated with biomedical therapies because of complexity, discomfort, bewildering technology or uncertainty of cure. Indeed, for some conditions, biomedicine has little or nothing to offer…For almost all, CAM approaches represent an attempt to gain a sense of control over their child’s chronic illness or disability and to improve quality of life.”

The American Academy of Child and Adolescent Psychiatry’s Practice Parameter for the Assessment and Treatment of Children and Adolescents with Autism and Other Pervasive Developmental Disorders, provides perhaps the best guidance on this issue:
“Clinicians should specifically inquire about the use of alternative/complementary treatments, and be prepared to discuss their risk and potential benefits [CG]. Although most “alternative” or complementary treatment approaches have no empirical basis to support their use in children with ASDs they are commonly pursued by families. It is important that the clinician be able to discuss these treatments with parents, recognizing the motivation for parents to seek all possible treatments. In most instances, these treatments have little or no proven benefit, but also have little risk. In a few instances, the treatment has been repeatedly shown not to work (e.g., facilitated communication, IV infusion of secretin). Some treatments have greater potential risk to the child either directly (e.g., adverse reactions to chelation treatment, or side effects due to contaminants in “natural” compounds) or indirectly (e.g., by diverting financial or psychosocial resources). While controlled studies of these treatments are needed, it is important that the family be able to voice their questions about these treatments and that their interest in such treatments can be discussed with health care providers.”

To be an effective health care provider and advocate for children with developmental disabilities, the child psychiatrist must be willing to engage with families concerning the issue of CAM treatments and assist them in making the best decision possible for their child.

XI. CONCLUSION: THE MULTIPLE ROLES OF THE CHILD AND ADOLESCENT PSYCHIATRIST IN PROVIDING SYSTEM-BASED CARE FOR CHILDREN AND ADOLESCENTS WITH DEVELOPMENTAL DISABILITIES

To be an effective health care provider and advocate for children with developmental disabilities, the child psychiatrist must be flexible and be willing to play multiple roles in the community-based care of children and adolescents with developmental disabilities and their families. These roles include:

- **System Navigator**, to assist families by having a good working knowledge of the organizational structure of services for children with developmental disabilities on the state and local level. The System Navigator must also assist with transition from service array to service array as the child with a developmental disability grows older.
- **Medical Case Manager**, to assist with access to services or to identify and collaborate with the local case managers of services for persons with a developmental disability. In order to efficiently link a child with a developmental disability to services, the Medical Case Manager must be aware of the mix of institutional and community-based services and supports available in their area. The Medical Case Manager must also be aware of the resources that may be available through that state’s UCEDD.
- **A sensitive and thoughtful assessor of guardianship needs for an individual with a developmental disability.** The child psychiatrist must also address the issue of CAM with an equal degree of sensitivity and thoughtfulness.
- **An Advocate**, whether it is as part of a Child and Family Team (ISP process), a PCP process or simply as a member of the community, for access to needed services. The child psychiatrist may also need to be an advocate for the child and their family with the broader medical community to obtain needed medical or psychiatric services.
particularly when a behavior or physical symptom is thought to be caused by the developmental disability (“diagnostic overshadowing”).

- The medical member of a Child and Family Team or PCP process. The child psychiatrist can identify those future needs for the team that are dictated by the child’s genetic, neurological or other medical condition.
- Psychopharmacologist, providing treatment for both the comorbid psychiatric conditions that may be present and the behavioral manifestations of the developmental disability and coordinate such treatment with the equally important behavioral and psychotherapeutic interventions for the child.
- Psychotherapist to the family, supporting them as they grieve their dreams for their child with a developmental disability and cheer with them as the child makes much hoped for developmental progress.
- The child psychiatrist must also learn to adapt the skills they have developed working with typically developing children and adolescents in order to provide psychotherapy to an individual with an intellectual disability.
APPENDIX 1*

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;
2) coordinate patient care within the health care system relevant to their clinical specialty;
3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
4) advocate for quality patient care and optimal patient care systems;
5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,
6) participate in identifying system errors and implementing potential systems solutions.
7) know how types of medical practice and delivery systems differ from one another, including methods of controlling health care cost, assuring quality, and allocating resources;
8) practice cost-effective health care and resource allocation that does not compromise quality of mental health care for children and adolescents;
9) advocate for quality patient care and assisting patients in dealing with system complexities, including disparities in mental health care for children and adolescents;
10) work with health care managers and health care providers to assess, coordinate, and improve health care;
11) know how to advocate for the promotion of health and the prevention of disease and injury in populations; and,
12) instruct in the practice of utilization review, quality assurance and performance improvement.

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REFERENCES

SUGGESTED READING


You have been asked to participate in the child and family team for Michael, an eight year old boy whom you are treating for attention-deficit/hyperactivity disorder. The school has recently identified him as having a mild intellectual disability and a pervasive developmental disorder. His mother tells you that Michael has several cousins with learning problems and one uncle who has been diagnosed with autism and wonders if Michael’s problem “runs in the family.” Michael has also been treated with Tegretol for several years for a seizure disorder, but has not seen a neurologist since his diagnosis. The prescription has been refilled by the primary care physician, but Michael has recently started to have “staring spells” again.

1. As “Medical Care Manager” for the team, what consultations would you arrange?

2. The child and family team is working on an Individualized Service Plan for Michael and his family.
   a. Who is on the team?

   b. What is the purpose of the ISP?

3. What is the role of Michael’s CAP?

4. What manual could help guide the CAP in his/her work with Michael?
5. Michael’s CAP could receive training or technical assistance from what state resource?

6. What is the focus of the UCEDD?
Garrett was diagnosed several years ago with autism and his family is looking desperately for ways to increase his sociability and improve his language skills. Several medication trials have not improved his symptoms as much as his parents would have liked. The last medication trial with Risperdal caused Garrett to gain 20 pounds, which greatly alarmed his mother and father.

Garrett’s parents come to you seeking guidance about the use of complementary and alternative medicine. They have heard about special diets, megavitamin treatment and even chelation, but are unsure how to proceed.

1. What advice do you give them?

2. Of the three interventions listed above, which carries the least risk and which carries the most?

3. The American Academy of Pediatrics described some reasons for parents seeking CAM treatments such as:
Linda is a twelve year old girl who moved with her family to your state during the summer. She had been failing in her regular classroom for the past three years and had been called a “slow learner.” She has been in school for four weeks and already the teacher has noticed that Linda is not keeping up with the other students academically. You are a child psychiatric consultant to a pediatrics practice and Linda’s mother has voiced her concerns about her problems at school. She also reports that Linda’s developmental milestones were delayed in comparison to her other children. You suspect that Linda may have a mild intellectual disability. Her pediatrician has asked you to help develop a plan for Linda.

1. What suggestions do you have for the pediatrician?

2. During your interview, Linda expresses sadness as she has begun to have some awareness of the differences between herself and the other children academically and feels “left out” from some activities by her classmates. What are your next steps?

It is now eight years later and Linda is graduating from high school and looking forward to starting full time work at the veterinarian’s office where she has been working part-time over the last two years through a vocational program at school. Linda has successfully traveled from school to work and then home on public transit without problems for over a year. She is hoping to share an apartment with a friend from school once she has saved up enough money for her portion of the security deposit.

3. Her parents express their concerns about Linda living on her own and are asking you whether or not they should pursue guardianship for her. What is your assessment of the issue?
4. What is Person Centered Planning process?

5. What has Linda already identified as a specific future goal that could be addressed with a PCP process?