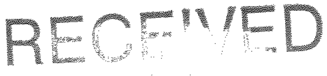

BEFORE THE IOWA MEDICAL CANNABIDIOL BOARD

Petition by *(Your Name)*

for the (**addition or removal**) of

severe, intractable autism with self-injurious or aggressive behaviors, all ages

(*medical condition, medical treatment or debilitating disease*) to the list of debilitating medical conditions for which the medical use of cannabidiol would be medically beneficial.

PETITION FOR
ADDITION or **REMOVAL**
(Circle one)

Petitioner's Information				
Name (First, Middle, Last or Name of Organization):				
Home Address (including Apartment or Suite #):				
City:		State: IA	Zip Code:	
Telephone:	Email Address:			
Is this the person/ organization to whom information about the petition should be directed?			**Yes** ☒	**No** ☐

Representative's Information (*If applicable*)				
Name (First, Middle, Last):				
Mailing Address (including Apartment or Suite #):				
City:		State:	Zip Code:	
Is this the person/ organization to whom information about the petition should be directed?			**Yes** ☐	**No** ☐

Telephone Number:	Email Address:

1. Please provide the name of the specific medical condition, medical treatment, or debilitating disease you are seeking to add to or remove from the list of debilitating medical conditions for which patients would be eligible to receive a medical cannabidiol registration card. *Please limit to ONE condition, treatment, or debilitating disease per petition.*

Recommended Action	Condition or Disease
☑ Add ☐ Remove	Severe, intractable autism with self-injurious or aggressive behaviors, all ages

2. Please provide a brief summary statement that supports the action urged in the petition. *Attach additional pages as needed.*

See attached letter to Board and following documents:

(1) Woodward Integrated Review 2/13/2019
(2) Woodward Documents including Program approval form, graph of behaviors, behavior support plan, implementation program reports
(3) Annual Psych Review + graph
(4) Annual Review / Screening
(5) Individual support Plan
(6) U of I admission

3. Please provide a brief summary of any data or scientific evidence supporting the action urged in this petition. *Attach additional pages as needed*
See attached # 3 and Anecdotal Support

4. Please provide a list of any reference material that supports your petition.
See attached # 4

5. Please provide a list of subject matter experts who are willing to testify in support of this petition (if any). The list of subject matter experts must contain names, background, email addresses, telephone numbers, and mailing addresses. *Attach additional pages if needed.*			
Name	(1)	(2)	(3)
Background			
Email address			
Telephone number			
Mailing address			

6. Please provide the names and addresses of other persons, or a description of any class of person, known by you to be affected by or interested in the proposed action which is the subject of this petition. *Attach additional pages if needed.*
See # 6 attached letters of support

7. Please indicate whether you have attached a brief in support of the action urged in the petition.	Yes	No
	☐	☑

8. Please indicate whether you are asking to make an oral presentation of the contents of the petition at a board meeting following submission of the petition.	Yes	No
	☑	☐

9. Acknowledgement and Signature

By signing this document I certify that the information provided in this petition is true and accurate to the best of my knowledge.

Signature ____________________ 3/5/2019
Date (mm/dd/yyyy)

- Please fill out each section that is applicable to your petition. Failure to conform to what is required in this petition may result in a denial of consideration by the board.
  - You do not need to fill out sections asking for your representative's information if you do not have one.
  - For section **2**, please provide a short, essay-like summary of your argument.
  - For section **3**, please provide a short, essay-like summary of the articles and evidence that supports your position (if any).
  - For section **4**, please provide a list of articles that are in support of your position (if any).
  - For section **5**, please provide a list of experts that would be willing to testify in support of your position (if any). In the background section, please provide the reasons why they should be considered experts in the area: education, credentials, field of study, occupation, etc. This section is optional but will greatly aid in helping the board consider your petition.
  - For section **6**, please provide information about groups of people that will be affected if the petition were approved. This could include people suffering from a specific disease, advocacy groups, local government officials, etc.
  - Sections **7** and **8** are optional but may aid the board in considering this petition.
- Please be aware:
  - The board may request that you submit additional information concerning this petition. The board will notify you of the requested materials in the event that more information is needed.
  - The board may also solicit comments from any person on the substance of this petition. The board may also submit this petition for a public comment period where any interested person may comment.
  - The board has six months after you submit this form to either deny or grant the petition. If approved, you will be notified in writing that the board has recommended the addition or removal of the medical condition, treatment, or debilitating disease to the board of medicine. If denied, the board will notify you in writing the reasons for denial.

- If the board denies your petition for failure to conform to the required form, you will be allowed to correct the errors and resubmit for consideration.
- **After you have completed this petition, please make sure that you sign, date it, and email, mail, or hand deliver to:**

Iowa Department of Public Health
Office of Medical Cannabidiol
Lucas State Office Building
321 E. 12th Street
Des Moines, IA 50319-0075
Email: iamedcbd@idph.iowa.gov
Phone: (515) 281-7996

March 4, 2019

Iowa Department of Public Health
Office of Medical Cannabidiol
Lucas State Office Building
321 E. 12th Street
Des Moines, IA 50319-0075
Email: medical.cannabidiol@idph.iowa.gov

Dear Members of the Medical Cannabidiol Board,

On November 27, 2018, the Iowa Medical Cannabidiol Board issued an order that modified a petition to add Autism Spectrum Disorder (ASD) as a debilitating medical condition for which the use of cannabidiol would be medically beneficial. Specifically, the Cannabidiol Board modified and recommended the addition of severe, intractable *pediatric* autism with self-injurious or aggressive behavior.

This recommendation, submitted to the Iowa Board of Medicine, was made based upon a petition involving a child with ASD. As the Cannabidiol Board noted in its order, "ASD refers to a group of complex neurodevelopment[al] disorders characterized by repetitive and characteristic patterns of behavior and difficulties with social communication and interaction."[1] Because of "the wide range of symptoms, skills, and levels of disability in function" that occur in persons with ASD and the potential negative effects the use of medical cannabidiol may have on the developing young brain, the Cannabidiol Board felt it important to limit the use of medical cannabidiol to those children with severe autistic symptoms included self-injurious or aggressive behaviors. Thus, the recommendation to the Iowa Board of Medicine was limited to children with severe autism.

[1]Sarah E. Fitzpatrick et.al, *Aggression in Autism Spectrum Disorder: Presentation and Treatment Options*, Neuropsychiatric Disease and Treatment (Dove Medical Press Ltd., June 23, 2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4922773/.

At the December 13 and 14 meeting of the Board of Medicine, that Board voted to notice rules which would add severe, intractable *pediatric* autism with self-injurious or aggressive behavior to the list of debilitating medical conditions approved for the use of medical cannabidiol.

I am the mother of a 28-year-old young man with severe autism with self-injurious and aggressive behaviors. When I learned in January that the recommendation specified pediatric autism, I contacted the Cannabidiol Board and the Board of Medicine to inquiry as to the recommendation's applicability to adults with autism. I attended the February 1, 2019 Cannabidiol Board meeting and the February 5, 2019 Board of Medicine meeting. I also submitted a letter to the Board of Medicine requesting an amendment to the proposed rulemaking to remove the word "pediatric" and make it all ages. The essence of that letter is contained in this petition. At both meetings, board members were supportive of my request. However, the Board of Medicine explained it was unable to modify the recommendation at this juncture and encouraged me to submit a petition to the Cannabidiol Board to add "severe, intractable autism with self-injurious or aggressive behaviors, *all ages*" to the list of debilitating medical conditions for which medical cannabidiol would be allowed.

As I previously stated, my adult son, , has severe autism with self-injurious and aggressive behaviors. These behaviors began to develop when was an adolescent, though his diagnosis of autism and severe intellectual disability was made when he was three years old. Many treatments, including psychiatric medications, were tried, most with limited benefit and several with serious side effects including facial tics and constant tremors.[2] In total, has been treated with in excess of twenty psychiatric drugs, including the only two drugs actually approved for the treatment of autism in children, Risperdal

[2]*See* Lauren Gravitz, *Autism's Drug Problem*, Scientific American (April 24, 2017) [hereinafter Gravitz], https://www.scientificamerican.com/article/autisms-drug-problem; *see also* Sheena LeClerc & Deidra Easley, *Pharmacological Therapies for Autism Spectrum Disorder: A Review*, Pharmacy and Therapeutics (June 2015) [hereinafter LeClerc], https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4450669/ (discussing approved and off-label pharmacotherapeutic options for the various symptoms of ASD and their potential benefits and side effects); Jeremy Kossen, Blog, *How Does Cannabis Consumption Affect Autism?*, Leafy (May 19, 2016) [hereinafter Kossen] (noting that numerous "experimental" and "off-label" drugs that carry their own risks are used for persons with autism). When on Risperdal, Jared developed tics, tongue thrusting, grimacing, and uncontrolled body movements. Though the symptoms have lessened, he continues to have facial tics and possibly some uncontrolled body movements.

and Abilify.[3] Diets and supplements were also explored with no significant improvement. He was seen at the University of Iowa Centers for Disability several times for recommendations. More and different medications were tried. When he was in his late teens and early twenties his behaviors were so extreme, including running and throwing himself at windows, that he was hospitalized in the psychiatric department at the University of Iowa Hospitals and Clinics for ten days. Despite multiple medication adjustments, he did not improve. Shortly before his 21st birthday, we made the difficult decision for his admittance to the Woodward Resource Center in Woodward, Iowa.

has resided at the Resource Center since that time. Since admission, the number of serious psychiatric medications he takes has been reduced in number; however, he still receives at least three psychotropic drugs daily.[4] And he continues to engage in self-injurious and aggressive behaviors. Some of the self-injurious behaviors my son engages in on a regular if not daily basis include hitting himself, especially about the ears and face; biting and slapping himself; dropping to the floor with force that he has damaged his skin and joints; and running into walls and objects. Hitting himself about the ears has resulted in damage to the outer cartilage of both ears, and he has what is sometime referred to as "cauliflower or wrestler's" ears. also bites objects and clenches his jaw very tightly when he is agitated. On occasion, he has chipped his teeth. Last year, he had a molar extracted at the University of Iowa Hospitals and Clinics for what they believed was an infected tooth. It was thought that the tooth may have become infected as a result of a cracked tooth. It is also believed that he may suffer from TMJ, though it has been difficult to confirm this diagnosis because he is essentially nonverbal and uncooperative with testing. He takes Aleve and Tylenol daily because it is felt that he is experiencing pain. This necessitates the use of Prevacid and Ranitidine to prevent GI issues secondary to the NSAID use.

[3]Gravitz, supra ("The U.S. Food and Drug Administration has approved only two drugs for children and adolescents with autism: risperidone (Risperdal) and aripiprazole (Abilify), both atypical antipsychotics prescribed for behaviors associated with irritability, such as aggression, tantrums and self-harm."). Some of the drugs that Jared has been on include Celexa, Luvox, Paxil, Prozac, Tenex, Adderall, Ativan, BuSpar, Xanax, Depakote, Neurontin, Risperdal, Seroquel, Geodon, Haldol, Thorazine, Namenda, Abilify, Lithium, Inderal, and Trazadone.

[4]He is currently on Celexa, Depakote, Namenda, and Lithium. At bedtime he takes Ambien.

The aggressive behaviors that he engages in include hitting, slapping, kicking and pushing others. Sometimes these actions appear undirected; is just trying to get away and someone is in his path. Other times, he appears to be releasing whatever pain or frustration he is having on those near him. He also engages in destructive behaviors that involve damaging furniture, including his bed; damaging his walls; throwing objects; and chewing and tearing his clothing. As a result, bedroom walls are padded, and he has a soft helmet that is offered to him or applied whenever he is experiencing extreme agitation.

His severe communication and social deficits make it very difficult to determine what triggers his self-injurious behaviors and aggression. One minute he will be calm and the next he will be beating himself about his ears and face, jumping up and down, and flinging himself about the room. is 6' 4" tall and his weight fluctuates between 170 and 190 lbs. When he is agitated, he is often very difficult to control and his safety and the safety of those around him can be at risk. Assessments made at the Resource Center suggest that his outbursts "are maintained by a combination of social variables, *[p]rimarily pain* and secondarily by escape."

As will be discussed under #3 of this application, scientific literature suggests that persons with autism suffer from immune system dysfunction and accompanying inflammatory conditions which may account for pain which results in symptomology in the form of self-injurious behaviors, emotional outbursts, destructive behaviors, and aggression.[5] Since has been

[5]The literature also suggests that medical cannabidiol may be beneficial in treating some of the other conditions/symptoms autistic persons are prone to including anxiety, insomnia, and gastrointestinal problems. *See* Finale Doshi-Velez, et. al, *Prevalence of Inflammatory Bowel Disease Among Patients with Autism Spectrum Disorders*, Inflammatory Bowel Diseases (October 2015), https://academic.oup.com/ibdjournal/article-abstract/21/10/2281/4644914?redirectedFrom=fulltext ("Across each population with different kinds of ascertainment, there was a consistent and statistically significant increased prevalence of IBD in patients with ASD than their respective controls and nationally reported rates for pediatric IBD."); Waseem Ahmed & Seymour Katz, *Therapeutic Use of Cannabis in Inflammatory Bowel Disease*, Gastroenterology & Hepatology (Nov. 2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5193087/pdf/GH-12-668.pdf (reporting on a study done on 30 Crohn's patients with chronic intractable pain legally using cannabis due to a lack of response to conventional treatments and concluding the need for large double-blind studies to establish object improvement yet noting that all 30 patients rated their general medical well-being as improved after cannabis use accompanied by a decrease in the use of corticosteroids and other medications while using cannabis); Gooey Rabinski, *Can Cannabis Treat Autism?*, MassRoots (Aug. 31, 2015), https://www.massroots.com/learn/cannabis-treatment-autism/ ("Cannabis helps relieve many of the symptoms suffered by autistic children and adults, including hyperactivity, attention disorders, seizures, panic disorders, anxiety, destruction of property, and self-injury.").

residing at the Resource Center, statistical data has been collected reflecting the occurrences of these behaviors. Often the monthly occurrences of these behaviors are in the hundreds. At times, the data will reflect a decrease over a period of months only to have a subsequent sudden resurgence for unknown reasons. Clearly, the pharmacological options that have been tried with have not been altogether successful and are not without great cost themselves to his physical well-being.

I could provide dozens of anecdotal stories of self-injurious behavior and even some pictures of the injuries he has inflicted upon himself.[6] However, I want to respect privacy as much as I can. Therefore, I am including in this application a sampling of his past school reports, medical records and evaluations, and monthly reports from the Resource Center that establish the behaviors which I have described. I ask the Boards not to make his name public.

I also understand that the clinical research regarding the therapeutic benefits of cannabidiol in general, and with autism in particular, is limited, in part due to the Schedule I status given to cannabis.[7] And the research involving autistic adults is even less.[8] However, there is some scientific data or evidence and many anecdotal reports suggesting medical cannabidiol may be therapeutically beneficial to persons with severe autism.[9] When an exhaustive

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[6]That you might understand how severe his behaviors can be, there was one incident where he banged his head with such force that he caused a laceration about 1" long which needed stitches. Because he was unable to cooperate with that medical procedure at the Resource Center, he was taken to the ER and medical glue was used. Glue only works so well, and Jared repeatedly reopened this wound. It eventually healed after about a year.

[7]*See* Kossen, supra ("While you can now find 562 clinical studies . . . involving cannabis listed on ClinicalTrials.gov—not one involve[s] . . . autism."). *But see Marijuana May Be a Miracle Treatment for Children With Autism*, USA Today (April 25, 2017), https://www.usatoday.com/story/news/world/2017/04/25/marijuana-pot-treatment-children-autism-cannabis-oil/100381156/ (discussing clinical trial being conducted in Israel involving 120 children *and young adults, ages 5 to 29,* who have mild to severe autism).

[8]*Does Marijuana Have Medical Benefits for People Diagnosed with Autism?*, https://inhalemd.com/blog/does-marijuana-have-medical-benefits-for-people-diagnosed-with-autism/ (noting "[t]here are currently no studies charting the effects of Cannabis use on *adults* diagnosed with ASD, but the effects observed in child subjects may extend to older patients.").

[9]D. Siniscalco, et.al, *Cannabinoid Receptor Type 2, But Not Type 1, Is Up-regulated in Peripheral Blood Mononuclear Cells of Children Affected By Autistic Disorders*, Journal Autism Developmental Disorder (Nov. 2013), https://www.ncbi.nlm.nih.gov/pubmed/23585028 ("Our data indicate CB2 receptor as potential therapeutic target for the pharmacological management of the autism care.).

number of approved and off-label medications have failed, the chance that something like medical cannabidiol might provide some benefit should not be rejected.[10] The severity of symptoms does not decrease merely by turning 18.

It is because of the severe nature of his condition, his inability to communicate how he is feeling, and his lack of response to many medications, some with very serious side effects, that I would like for and other adults with severe autism to have the opportunity to see if medical cannabidiol would provide some benefit. I believe that this medical condition warrants addition to the list of conditions eligible to receive a medical cannabidiol registration card. I would ask the Medical Cannabidiol Board to recommend removing the pediatric restriction and adding "severe, intractable autism with self-injurious or aggressive behaviors, *all ages*" to the list of debilitating medical conditions for which individuals would be eligible to receive a medical cannabidiol registration card.

Sincerely,

Jocelyn M. Sbiral

Jocelyn M. Sbiral

Mother and Guardian of

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[10]As one mother facing criticism from some in the medical and scientific communities for treating her autistic child with cannabis responded, "Until you've walked in my shoes. Until you've walked in Joey's shoes. Until you've seen where a child was before cannabis, how much progress they've made after cannabis, and how much their lives can improve, who is anyone to pass judgment?" Kossen, supra.

Individual Nutritional Management Plan

Name: ID# Address:

Date Reviewed: 11/06/14, 10/08/15, 9/01/16, 7/25/17, 6/25/18 Date Revised: **12/19/14, 9/21/18**

Support:	Feeds self Staff sit within arm's reach
Seating/Positioning:	Regular dining chair Encourage to remain upright for 60 minutes after oral intake as a GERD precaution.
Adaptive Equipment:	-Deep divided dish -Regular bowl -Regular utensils -Regular glasses
Food Textures:	-Regular diet texture -Food cut into bite sized pieces
Liquid Consistency:	-Thin liquids

If you have any questions/concerns about this plan, please contact any of your PNM house team members.

Specialized Interventions **At Risk**

Risks: **Dysphagia, GERD**

Name: ID#: Address:

Mealtime Procedures:

Behavioral Issues:	**-May prompt to put utensil down between each bite if has SIB or other interfering behaviors.** **-Refer to BSP if is requesting to eat/drink on night shift.**
Spooning: is able to scoop his food but will overload his spoon and take big bites.	-Provide verbal prompts to take small bites. If he does not respond to verbal prompt give physical prompt of helping him reload his spoon.
Drinking: will take large drinks.	**-Give liquids ½ glass at a time.**
Skills to Maintain/ Acquire:	Working on reducing frequency of prompts needed for safe dining.

Triggers: If trigger occurs, notify nurse and record on DAR. Begin an action plan.

-Any general trigger

Community Outings:

Must always follow prescribed food texture and liquid consistency.

Level of assist/support: Self-feed

Supervision: Within arms reach

Equipment: See adaptive equipment list.

Positioning: Chair or booth, staff within arms reach.

Woodward Resource Center Integrated Review

Name: ________ **Client#:** ________ **Address:** ________

Review Date: 2/13/2019 **Date of last ISP review:** 6/25/2018 **County of Settlement:** Polk

INDIVIDUAL SUPPORT PLAN REVIEW			
Previous Action Plans			
Were all action plans completed? Yes ☐ No ☐ (If no complete the following action plan)			
About			
What people like and admire, characteristics of those who support, successes (ISP-1)	What is important to...		
Note updates to ISP. Explain: significant events, progress, assessments completed, action needed.			
family continues to visit every weekend. His mother recently purchased him a keyboard. -- Brenda Kruger, Social Worker 2 2/11/2019 Current wage is $.50 per hour. -- Mandy Johnson, Act Spec 1 2/11/2019			
Action Plan WHAT	WHY	WHO	BY WHEN
Keeping Healthy and Safe			
Medical, Nursing, Mobility, Nutritional Supports, Vision, Hearing, Behavioral, Risks	BSP Data reviewed: Target behavior, Replacement Behavior, Behavioral Indicators		
Comprehensive Care Plan Data			
Level of supervision (if increased, explain below): General			
Note updates to ISP. Explain significant events, lack of progress, assessments completed, what's working, action needed.			

Health and medical: Explain significant events, progresss or lack of progress, assessments, completed, consultations, what's working, action needed, and/or updates to ISP.

Monthly Review for January 2019
HSSP review: Constipation
S: is At Risk for Constipation. He has a diagnosis of Constipation and receives routine Miralax. There have been no triggers for constipation reported this month; no additional interventions were indicated.
O: is currently At Risk for Constipation. He receives Miralax 17gm Twice Daily and has a PRN order for Bisacodyl suppository, which he hasn't needed. His January Meal Intake: Total-62%, 3/4-10%, ½-9%, ¼-4%, R-10% compared to December: Total-89%, 3/4-3%, ½-3%, ¼-4% with no and November: Total 72%, 3/4-14%,1/2-11%, ¼-35. Overall meal consumption has decreased in January, there were no PNM triggers noted. His Wt. /BMI in February is 187/23.1, in January-190/23.4 compared to December-191.6/23.3. He is now being weighed weekly due to the steady increase in weight. A healthy weight range for someone of height is 150-203. spends a lot of time in his room per his choice, but at times he will be out in the living room of his side of the living unit. He walks independently. There are no related med changes or lab/test results to report.
A: He is At Risk for Constipation with a diagnosis of Constipation and receives non-fiber laxative, no additional interventions were required for Constipation.
P: Continue HSSP.

Other health concerns:
2/6/19 Ear check, no cerumen or redness
1/23/19 Ear check, no redness or cerumen
1/09/19 Ear check follow-up-clear, no redness or cerumen
1/2/19 Ear check, cerumen-Debrox initiated
12/20/18-Ear checks-clear, no redness or cerumen
12/5/18-Ear checks-clear, no redness or cerumen
11/21/18-Ear check-clear, no redness of cerumen
11/15/18-Quarterly nursing assessment-unremarkable, with reported VS: BP 106/54, P-76, T-98.2, Sp02-100%, R-18
10/24/18 Ear wax drops were completed and ears were irrigated and soft cerumen was returned, will continue weekly ear monitoring. Tympanic membrane visible.
10/24/18 Bi-weekly cerumen assessment revealed moderate amount of dark brown cerumen, Ear wax drops were initiated three time daily x 5 days,
10/3/18 Bi-monthly Cerumen Assessment: Bilateral ears have scant amount of cerumen. Tympanic membrane visible bilateral. No redness or irritation seen.
MOSES-11/15/18(2),8/28/18 (6), 5/16/18 (2), 3/14/18 (3), 12/19/17 (4), 9/6/17 (4), 6/27/17 (8), 5/3/17 (10)
FBS-11/12/18(89), 8/9/18 (84), 5/15/18 (71), 2/5/18 (88), 11/16/17 (92), 8/3/17 (82
LABS:
12/04/18 Lithium-0.64

9/18/18 BMP-WNL (k+-4.4),Valproic Acid-38.5 (L), Lithium-0.78
9/17/18 CBC-WNL, CMP-Glucose-108 (non-fasting)K=-5.5 (H), SGOT-10 (L)
9/10/18 Lithium-0.85, Creatinine-0.8, TSH-2.99
5/30/18 EKG: Normal EKG. Sinus Rhythm/ rate 75
5/8/18 CBC/CMP all WNL. Valproic Acid: 50.3
6/12/17 Valproic Acid- 61.4, CBC/diff- WBC-4.0 (L) rest WNL, CMP-WNL, Glucose-78, Cholesterol-133, Triglyceride-96, HDL-38 (L), LDL-76
7/19/16 CBC- RBC 4.0 (L) rest WNL, CMP- WNL, Valproic Acid Level- 64.0
Wears a soft helmet as needed for prevention of head injuries.
Topical treatment of Zinc Oxide BID as needed for minor skin abrasions.
-- Lisa Murray, RN 2/07/2019
-- Lisa Murray, RN 2/12/2019
JSP:A.1./PNM review (1/09/19-2/11/19). PNM risk: At Risk. No risk events or referrals. No changes made. Plan supports address PNM needs.
-- Paula Pifer, Speech Pathologist 2/12/2019

Incident Reports (explain any trends in type, location, etc).

no I & Is
-- Kristina Hollingshead, Treatment Program Manager 2/13/2019

Behavioral and Mental Health: Explain significant events, progresss or lack of progress, assessments, completed, consultations, what's working, action needed, and/or updates to ISP.

Hit the wrong button in the Help [illegible] to be successful section. Sorry.
-- Janice Munson, Psychologist 2/4/2019

Action Plan WHAT	WHY	WHO	BY WHEN

Help [illegible] to be successful

Relationships/Socialization, Communication, Community Involvement, Home Life, School/job/retirement, Leisure, Self Care, Transportation, Dining, Money	Priority Needs/Adaptive skills data

Note updates to ISP. Explain significant events, lack of progress, assessments completed, what's working, action needed.

Notes auto-copied from HC: New program objective: During a practice audiology visit, with 2 or less verbal prompts, [illegible] will wear the audiology headphones for 15 consecutive seconds, 75% of weekly trials for 3 consecutive months by 1-16-2019.

Trials were run at the house using noise canceling headphones. [illegible] wore these with ease and appeared to enjoy them for long periods of time (30+ minutes). Trials were also run in the audiology booth with the noise canceling headphones. He wore them for less time in the booth, but still wore them for several minutes at a time. [illegible] appears to dislike the specific audiology headphones. The objective focuses on desensitizing [illegible] to these headphones specifically.
-- Alana Rohret, Psych Assistant 1/18/2019
Notes auto-copied from CS: Program revised after two months of decline. [illegible] will engage in a variety of tasks or activities five times each AM shift and five times each PM shift with 3 verbal prompts or less for each task/activity 75% of opportunities.
-- Alana Rohret, Psych Assistant 1/18/2019
Notes auto-copied from CS: Revision to correct objective the year in the objective due date.
-- Alana Rohret, Psych Assistant 1/18/2019
Notes auto-copied from CS: Program review for January [illegible] will engage in a variety of tasks or activities five times each AM shift and five times each PM shift with 3 verbal prompts or less for each task/activity is showing 58% after an incomplete month of data following revision, continue with the program.
-- Alana Rohret, Psych Assistant 2/1/2019
Notes auto-copied from HC: Program review for January-During a practice audiology visit, with 2 or less verbal prompts, [illegible] will wear the audiology headphones for 15 consecutive seconds, is showing 0% after an incomplete month of data after beginning program on 1/18/19, continue with program.
-- Alana Rohret, Psych Assistant 2/1/2019
Notes auto-copied from HC: Program review for January- [illegible] will sit in Dental chair 80 seconds with 2 verbal prompts or less 100% of opportunities each month is showing progress at 75%, continue with the program.
-- Alana Rohret, Psych Assistant 2/1/2019
Notes auto-copied from SH: Program review for January [illegible] allowed staff to brush his teeth for 30 seconds, with 1 or fewer prompts, is showing progress from last month at 98%, continue with the program.

-- Alana Rohret, Psych Assistant 2/1/2019
Notes auto-copied from DOM: Jan 2019 program review

DOM:4 Rev 2/1/19
Data: Aug 10%; Sep 12%; Oct 0%; Nov 95%; Dec 80%; Jan 98%
Analysis: Revised in Feb to 80%
-- Janice Munson, Psychologist 2/4/2019
Notes auto-copied from SEN: Jan 2019 program review

SEN:3 (Rev 1/1/19)
Data: Jan 60%
Analysis: Outcome revised.
-- Janice Munson, Psychologist 2/4/2019
Notes auto-copied from BEH: Jan 2019 data review

BEH: 3 (Emotional Outbursts) Rev 1/7/19: Jan 128
BEH: 4 (Aggression) Rev 12/31/18: Dec 3; Jan 0
BEH: 5 (SIB) Rev 1/7/19: Jan 6
BEH: 6 (Damaging bed/mattress) Rev 10/21/18: Nov 3; Dec 0; Jan 0
BEH:7 (Attempting/Actual batteries) Rev 7/1/18: Jul 0; Aug 0; Sep 0; Oct 1; Nov 0; Dec 0; Jan 0

Ave. Hrs. Sleep/night: Dec 6.8; Jan 6.7; Feb 6.8; Mar 6.5; May 6.6; Jun 6.5; Jul 6.5; Aug 6.5; Sep 6.4; Nov 6.8; Dec 6.4; Jan 6.4
HCD:J & K (# Hel worn & min): May 27 times/197 min; Jun 11 times/44 min; Jul 27 times/272 min; Aug 90 times/656 min.; Sep 16 times/114 min; Oct 9 times/52 minutes; Nov 1/7 minutes; Dec 0 times/0 min; Jan 0 times/0 min

Analysis of Behavioral Objectives:
BEH:3 (EO)Revised in January due to months decline.
BEH:4 (Agg) Progress noted.
BEH:5 Revised due to 2 month decline..
BEH:6 Progress noted.
BEH:7 (Attempting/Actual Batteries). Progress noted. He has 3/12 months

Nov I&I was recorded for SIB (1/5/19) Waiting for his mother to come. Bruise to the cheek.

OT is working with the house on sensory issues. A "bouncy swing" is currently being tried: August 1.8 minutes; Sep 1.3min; Oct 1 min; Nov 1 min; Dec Sat in the chair for a total of 36 min for an ave of 1.17 min a day.

Other areas that are being tacked include:
Mouthing on times which came to Aug 262; Sep 167; Oct 177; Nov 171 Sensory vest: Aug1; Sep 1; Oct 7 times; Jan 95 times
Urinated on his clothing: Aug 176; Sep 114; Oct 145; Nov 149; Jan 142
Sitting on the toilet Aug 265; Sep 206; Oct 206; Nov 186; Jan 189
Weighted Vest: Jan 3 times/30 min.

Current BSP:3.1 revision 8/3/18 included the new program replacement and other programing ideas that are being tracked.

Restrictions include:
PSYMED - Celexa
PSYMED - Depakote
PSYMED - Ambien
PSYMED - Namenda

RACCs & EMODs due to destruction:
o RACC:- Locked Plexiglas cover over his own TV, DVD, etc. and secured to wall. FADING PLAN - When has not destroyed any of his entertainment items for 12 consecutive months (starting Aug 2018) the IDT will meet to determine how to fade this restriction.
o Update: 2/1/19 A new recording system was implemented to better track destruction of entertainment items..
o Currently, has 0/12 months with no destruction of any of his entertainment items. In Jan destruction of entertainment items was 3

o EMOD: Mattress and mattress topper enclosed in vinyl -. FADING PLAN - When has not destroyed any of his mattresses or bed frames for 12 consecutive months (starting Oct 2017) the IDT will meet to determine how to fade this modification.
o Update: 2/1/19 had 2 months towards meeting the criteria for fading.

RACC and Other due to SIB behavior:
o RACC: - secured batteries on personal entertainment items -FADING PLAN - The IDT believes at this time for health and safety that this RACC remains in place. It will continue to be evaluated monthly at monthly reviews. Note: at one time the RACC included batteries for public entertainment items at the house. It is now restricted to his personal items.
o Update: 2/1/19: has not mouthed a battery in 3 months..

o OTHER: Soft-shell helmet (contingent) FADING PLAN: When has went 12 consecutive months (starting Oct 2017) without requiring medical treatment for a head injury caused by SIB the IDT will meet to determine how to fade this restriction.
o Update: 2/1/19 had 0 I&Is 1/2019. He currently has 0/12 months towards meeting the criteria.
DENT - General anesthesia
-- Janice Munson, Psychologist 2/4/2019

Action Plan WHAT	WHY	WHO	BY WHEN

Vision for the Future

Barriers	Discharge Plan

Note updates to ISP. Explain significant events, lack of progress, assessments completed, what's working, action needed.

Identified barriers continue to be aggression, SIB, and emotional outbursts. mother/guardian continues to be updated weekly.
-- Brenda Kruger, Social Worker 2 2/11/2019

Action Plan WHAT	WHY	WHO	BY WHEN

Medications

Medications	Diagnosis	Index Behaviors
Ambien 10 mg daily HS (10 PM)	Insomnia disorder	
Hydrophilic cream am/hs both hands	Dry skin	
Bacitracin ointment 500 u/G top' am/hs	Open or red areas on skin	
Celexa (citalopram) 20mg am	Autism spectrum disorder	
Debrox 6.5% 3 drops each ear daily x 5 days *Nt	Prevention of GI SE d/t use of Naproxen	
Divalproex sodium (Dapakote) 750 mg AM and 7	Autism spectrum disorder	
Chewable multivitamin with iron in am	Nutrition	
Fluzone (Flu Vaccine) 1 x yearly	Immunization	
Hydrogen peroxide otic drops (10) q week	Cerumen	
Lithium Carbonate 600 MG am and 300 mg pm	Bipolar disorder	
Miralax 17gm BID	Constipation	
Namenda 10 mg BID	Autism spectrum disorder	
Prevacid (Lansoprazole) 30 mg BID	Prevent issues related toNaproxen use	
Aleve (Naproxen) 220mg BID	Presumed TMJ inflammation per ENT	
Ranitidine 150 mg BID	Prevention of GI SE d/t use of Naproxen	
Acetaminophen 650mg qid and once at noc prn	Discomfort	
Bisacodyl suppository if no BM x 48 hours prn	Constipation	
Zinc Oxide topically for minor skin abrasions Twi	Minor Skin Abrasions	

Medication Changes this Quarter

Medication	Date	Prior Dose	New Dose	Comments

Note updates to ISP. Explain significant events, lack of progress, assessments completed, what's working, action needed.

Psychotropic Medication Review

Action Plan WHAT	WHY	WHO	BY WHEN

QIR Summary (Optional - summarize discussion not addressed in categories above)

WOODWARD RESOURCE CENTER HUMAN RIGHTS COMMITTEE (HRC)
PROGRAM APPROVAL FORM

Individual: #: Address: Date Written: 2/7/19

Program Developer(s): J. Munson, Psychologist; K. Hollingshead, TPM; Guardian/Mother; RTW; IDT
LAST ELP DATE: 6/25/18 HRC EXPIRATION DATE 6/25/19 *(entered by HRC; see any exceptions below)*:

Type of Review (check one appropriate category and provide requested information)
☐ **Admission Review**
☐ **Annual Review: Is a new procedure or psychotropic medication included?** ☐No ☐ Yes (place asterisk next to new item below)
☐ **Initial Review: Person Currently Has No Items Requiring HRC Approval**
☒ **Non-Annual Review: Adding or Replacing Item** (*asterisk new item below). List any previously approved item being discontinued here:

☐ **Non-Annual Review: Expiration of Prior Short-Term HRC Approval** Place asterisk next to item(s) for which is expiring
☐ Other:

Conferees	Signature and Title	Date
PEER REVIEW	[signature], Psych	2/18/19
TPM	[signature]	02.18.19
HRC	[signature] / Chair	2/18/19
OTHER (specify)*		

*Some procedures may require additional supervisory or administrative approval. See WRC policies or procedures

Restrictions (RACC, EMOD, etc.)

Program Code #	Type of Restrictive Measure	Interfering Behavior	Maximum Time	Approval of HRC: Yes	No	Other **
BEH:3	EMOD: Locked Plexiglas cover over his own TV, DVD, etc. and secured to wall.	Emotional Outburst	✓			
*BEH:3	Secure Electronic Keyboard to a table/shelf in his room	Emotional Outburst	✓			
BEH:3	EMOD (to batteries)	Emotional Outburst	✓			
BEH:5	EMOD – Padded bedroom walls and sharp corners in bedroom.	Self-injurious behavior	✓			
BEH:3	EMOD - Mattress and mattress topper enclosed in vinyl material	Emotional Outburst	✓			
BEH:5	OTHER – soft helmet	Self-injurious behavior	✓			

Abbreviations: RACC = Restricted Access EMOD = Environmental Modification
** HRC facilitator uses this box to enter shorter approval limited to the specific item. For other situations, explain below or use other side

Psychotropic Medications (List total mg/day; specify if other than oral or liquid form)

Generic and Brand Name	Current Dose *(if renewal)*	Proposed Dose *(omit if renewal)*	Minimum Dose	Maximum Dose	Approval of HRC: Yes	No	Other **
citalopram/Celexa	20 mg		0 mg	40 mg	✓		
divalproex/Depakote	1500 mg		0 mg	3500 mg	✓		
Lithium	900 mg		0 mg	1800 mg	✓		
memantine/Namenda	20 mg.		0 mg	20 mg	✓		
zolpidem/Ambien	10 mg.		0 mg	10 mg	✓		

Positive Behavior Support and/or Skill to be Taught:

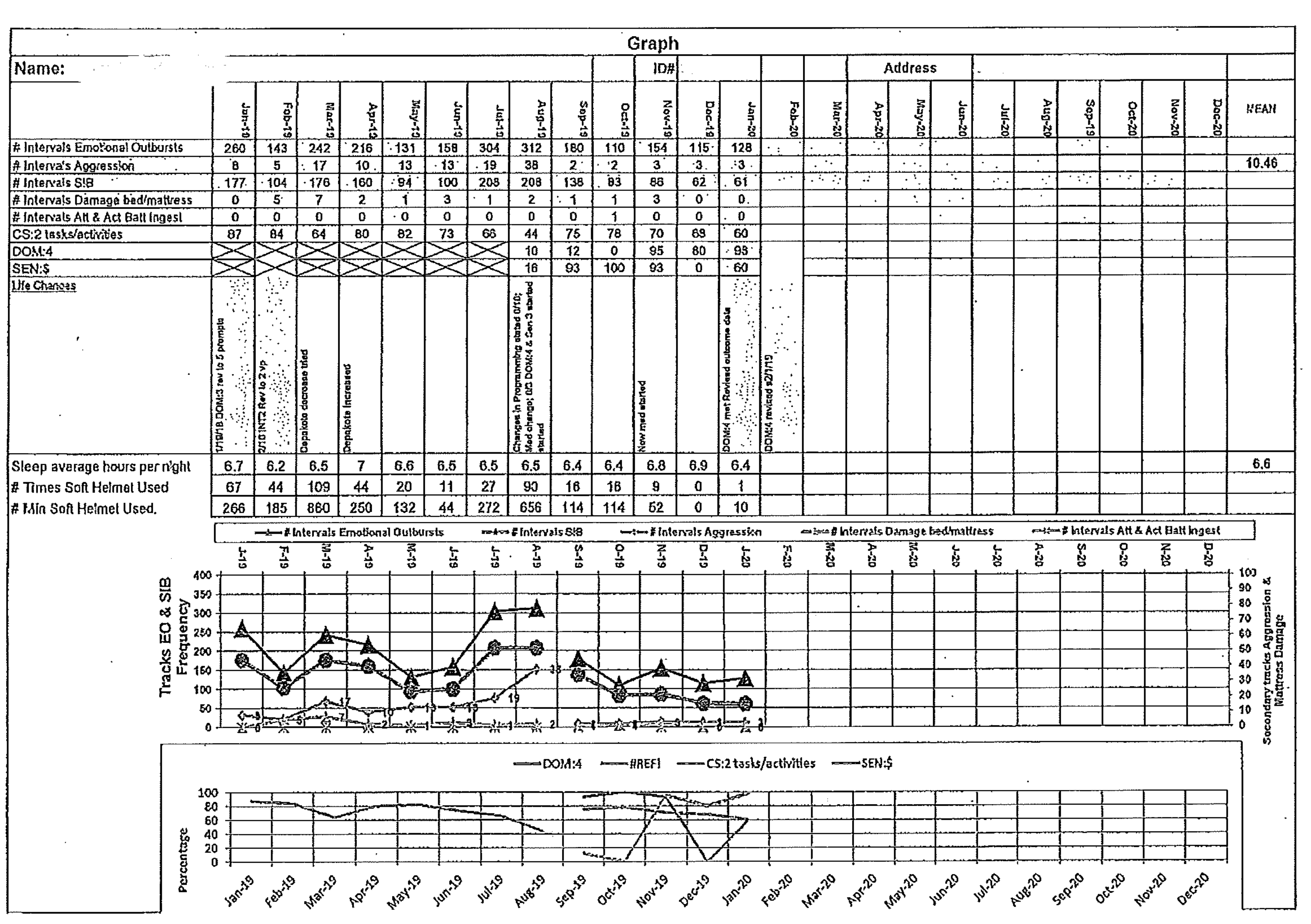
Program Code #	Specific Positive Behavior Support and/or Skill to be Taught
CS:2	Complete a variety of activities throughout his day
DOM:4	To organize and clean his room
SEN:3	Engages in a variety of sensory items.

Graph

Name:

ID#

Address



	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-19	Oct-20	Nov-20	Dec-20	MEAN
# Intervals Emotional Outbursts	260	143	242	216	131	158	304	312	180	110	154	115	128												
# Intervals Aggression	8	5	17	10	13	13	19	38	2	2	3	3	3												10.46
# Intervals SIB	177	104	176	160	94	100	208	208	138	83	88	62	61												
# Intervals Damage bed/mattress	0	5	7	2	1	3	1	2	1	1	3	0	0												
# Intervals Att & Act Batt Ingest	0	0	0	0	0	0	0	0	0	1	0	0	0												
CS:2 tasks/activities	87	84	64	80	82	73	66	44	75	78	70	68	60												
DOM:4	X	X	X	X	X	X	X	10	12	0	95	80	98												
SEN:$	X	X	X	X	X	X	X	16	93	100	93	0	60												
Life Changes	1/19/18 DOM:3 rev to 5 prompts	2/18 INT2 Rev to 2 vp	Depakote decrease tried	Depakote increased				Changes in Programming started 8/10; Med change; 8/3 DOM:4 & Sen 3 started started			New med started		DOM:4 met Revised outcome date	DOM:4 revised s2/1/19											
Sleep average hours per night	6.7	6.2	6.5	7	6.6	6.5	6.5	6.5	6.4	6.4	6.8	6.9	6.4												6.6
# Times Soft Helmet Used	67	44	109	44	20	11	27	90	16	18	9	0	1												
# Min Soft Helmet Used.	266	185	860	250	132	44	272	656	114	114	52	0	10												

- Definitions:

Things to Learn:

- Complete a variety of activities throughout his day

  To organize and clean his room

  Accept a variety of sensory items.

Early Warning Signs:

- Agitation: jumping, sweating , growling, making angry noises, making the statement that "you need to do that", slapping things, banging on items, flipping his items more rapidly than usual.

Behaviors To Reduce:

- Aggression (AGG): aggressing other people through hitting, slapping, kicking, pushing, etc...

  Emotional Outburst (EO): Dropping to the floor, throwing items, and/or breaking items

  Self-injurious behavior (SIB) includes slapping or hitting himself on the head/face or striking any body part against objects or surfaces. Incidents are bounded by 5 minutes.

  Attempted Ingestions includes mouthing or actually ingesting batteries.

  Damaging his bed or mattress consists of jumping on his bed and/or tearing his mattress

- The Psychiatrist Watches These
  Aggression, Emotional Outbursts, SIB and sleep

- **What To Keep Track Of:**

  - assigned group leader for each shift (AM, PM, & NOC) is to record each half-hour interval that an Aggression, Emotional Outburst, SIB, attempted ingestion or Damaging his bed or mattress occurred on the data sheet. Transfer the data to the IPFS in the electronic IPR record.

  - Record on the DAR if personal entertainment items where destroyed. To record destruction of personal entertainment items staff will document in an event log. AM & PM shifts will record the number of times sat on the toilet per shift.

  - Record on the DAR the number of times and the number of minutes per shift that Jared wears his soft helmet. Complete an I and I if ingests a battery. NOC staff will track hours of sleep on the sleep sheet and transfer to the DAR. AM & PM shifts will track the number of times sat on the toilet and record the data on the DAR. Staff on AM/PM/NOC will record

offer him his soft helmet to wear. Anytime he refuses to wear the helmet, e.g., takes it off, allow him to do so. Wait approximately 10 minutes and offer the soft helmet again if he has not calmed. Repeat this offer for a total of three times. If the helmet is refused a third time wait a period of about 15 to 30 minutes needs to occur before re-prompting or he reaches for the helmet or has calmed. is to wear the helmet for no longer than 110 minutes without it being removed for 10 minutes.

If ask for food during the NOC shift attempt to distract him and encourage him to watch a movie, listen to music, or sleep.

If ask for food two additional times provide him a drink and each time thereafter.

Encourage to get on and off the bus before anyone who does so slowly (due to him moving at a fast pace which can result in him pushing past others).

There are times likes to take naps during the day. Offer him the option of a weighted blanket once he lays down.

TO PROMOTE BETTER SLEEP

Support in getting more restful nights of sleep by doing the following.

Towards the end of PM shift, support staff will assist with preparing for the end of his day and bedtime.

1. Support staff will ask to use the toilet.
2. He will be asked to brush his teeth for last time of day.
3. He will put on his night clothes/pajamas.
4. He will be asked to put his sensory vest in the laundry barrel for washing.
5. He will put any clothing or shoes away in appropriate places.
6. He will be asked to pick out a movie for "bed".
7. He will be asked if he wants the weighted blanket on after he gets into bed.

If he refuses any step, ask him to complete the step and tell him "let's get ready for bedtime".

If wakes up on the NOC shift and is unable/unwilling to go back to sleep provide him with a movie/television show to watch in his room.

If he appears to want to destroy his keyboard: Say his name, ' ," try to establish eye contact and redirect him to another activity.

- **Rewards For a Good Job:**
  - Verbal praise for completing a task or activity.
  - A head rub, shoulder rub, or a pat on the back for completing a task or activity.

- **When Things Go Wrong:**
  - AGGRESSION, SIB OR EMOTIONAL OUTBURST, DAMANGING HIS MATTRESS:

When an Aggression, SIB or Emotional Outburst is observed:

Remain calm

Code: BEH:4 Goal: will decrease instances of Aggression (AGG)
Enroute Objective #: 2.9 Implemented: 12/31/2018 Met:
6/1/2019.

Code: BEH:5 Goal: will decrease instances of Self-Injurious Behavior (SIB)
Enroute Objective #: 1.13 Implemented: 1/7/2019 Met:
1/1/2020.

Code: BEH:6 Goal: will reduce instances of damaging his bed or mattress.
Enroute Objective #: 1.5 Implemented: 10/21/2018 Met:
11/1/2019.

Code: BEH:7 Goal: will decrease incidents of attempting (including mouthing) or actually ingesting batteries
Enroute Objective #: 1.4 Implemented: 7/1/2018 Met:
7/1/2019.

Code: CS:2 Goal: Complete a variety of activities throughout his day
Enroute Objective #: 1.8 Implemented: 2/14/2019 Met:
1/14/2020.

Code: DOM:4 Goal: To organize and clean his room
Enroute Objective #: 1.3 Implemented: 2/18/2019 Met:
9/1/2019.

Code: SEN:3 Goal: Engages in a variety of sensory items
Enroute Objective #: 1.3 Implemented: 2/18/2019 Met:
6/1/2019.

When Data is Collected: AM #1;AM #2;AM #3;AM #4;AM #5;PM #1;PM #2;PM #3;PM #4;PM #5;

Recording Instructions: Record Y=Yes, engaged in a variety of tasks or activities five times each AM and five times each PM shift with 3 verbal prompts or less for each task/activity; N=No, did not engage in a variety of tasks or activities five times each AM and five times each PM shift with 3 verbal prompts or less for each task/activity. N/A=The program was not able to be ran

Woodward Resource Center
Individual Implementation Program

Name: ______ **Client #:** ______ **Address:** ______ **Code:** ______

Monitor: Janice Munson, Psychologist **Author:** Keith Davis, Psychologist

QMRP: Kristina Hollingshead, Treatment Program Manager **Shifts to be Trained:** All

Long Term Goal: Engages in a variety of sensory items

ISP Justification/Generalization to Community Living:
He seems to become overstimulated in his environment at times and becomes agitated. Increasing his ability to manage himself with sensory items will increase his quality of life.

Baseline: 70 Percent

How Baseline was Obtained:
Average of data collected during the 3 month period ending with October 2018. Given 2 gesture and 2 verbal prompts or less, will participate in 1 trial on AM & PM shift with a sensory item for 1 minute

This IIP is a positive program associated with BSP:3

En Route Objective: 1 **Revision #:** 3 **Date Implemented/Revised:** 2-18-2019 **Date Met:** ______

Given 2 gesture and 2 verbal prompts or less, ' will participate in 1 trial on AM & PM shift with a sensory item for 1 minute at a rate of 95% for 3 consecutive months by 6-1-2019.

Procedures for Objective # 1

This program will be run once on AM & PM shift.

HAND HELD SENSORY ITEMS procedures for both trials on AM & PM shifts: (the time is a maximum of 1 minute) AM & PM shift pick trial times that are best for . Hand held sensory items are kept in the Activity Closet at the house.

Staff will have the hand held sensory item in their hand as a visual cue standing by the designated table where the trial activity will be held (This is not a prompt).

Gesture by holding the hand held sensory item and verbally prompt him (1 trial includes the following) (" let us sit at the table and please hold this") (1st gestural and verbal prompt).

1. If sits down at the table and
2. takes (holds) the item and
3. sits there for 1 minute (Staff will need to make sure they are timing this through counting, etc.).

It needs to be all 3 steps (sitting at the table, holding the item, and 1 minute to be successful to receive a 'yes'.

If he refuses any of the 3 steps retry after 5 minutes and prompt again. If refuses again mark a 'No' and try on the next shift.

Reinforcer:

High 5, smiles and/or verbal praise.

Data Collection:

Type of Data: Yes/No

When Data is Collected: AM;PM;

Recording Instructions: Record Y-Yes Given 2 a gesture and 2 verbal prompts or less, participated in 1 trial on AM & PM shift with a sensory item for 1 minute; N=No, did not, Given 2 a gesture and 2 verbal prompts or less, participated in 1 trial on AM & PM shift with a sensory item for 1 minute

1-24-14 – Replaced bottom waterproof mattress.
1-27-14 – Metal bed frame is bent – staff fixed bend in bed frame.
3-1-14 – New metal bed frame due to frame broken.
3-17-14 – Broken middle leg/support repaired.
11-7-14 – New mattress due to odor.
2-5-15 – Broken bed frame and center leg – items replaced or repaired.
3-3-15 – Adding 8 inch wooden frame on top of low profile bed frame in order to decrease the distance when plops on his bed.
3-4-15 – Replaced both waterproof mattresses.
10-8-15 – New XL waterproof mattress given.
12-3-15 – New XL waterproof mattress given due to destruction.
4-6-16 - New XL waterproof mattress given due to destruction.
9-30-16 – Order placed to fix bed frame and add wooden legs due to destruction and two geo mattresses will be trialed to reduce ability to destroy waterproof mattress.
10-30-16 – Orders put in to remove all of old bed frame and mattress and to replace with new frame and two hospital mattresses with plywood base. This replaces the 9-30-16 request.
12-13-16 – Two new XL waterproof mattresses ordered due to odor and destruction.
1-11-17 – One new waterproof mattress ordered due to seams coming apart on current mattress. Looking into purchasing more indestructible mattress to prevent from being able to destroy.
FADING PLAN – When has not destroyed any of his mattresses or bed frames for 12 consecutive months the IDT will consider discontinuing this restriction.

- Risk: OTHER: Soft Helmet to help calm and reduce potential injuries due to self-injurious behavior. Anytime is engaging in precursor behaviors or is engaging in SIB offer him his soft helmet to wear. Anytime he refuses to wear the helmet, e.g., takes it off, allow him to do so. This looks unusual when compared to community standards but does not impede with his activities of daily living. The helmet can protect from harm and considered low risk.
  Justification: Anytime is engaging in precursor behaviors or is engaging in SIB offer him his soft helmet to wear. Anytime he refuses to wear the helmet, e.g., takes it off, allow him to do so. On 10/21/14 doctor gave an order for him to wear a soft-non locking helmet while he healed from head injuries that resulted from SIB (banging his head on surfaces). could remove the helmet if he chose to do so but staff observed that he willingly wore the helmet on most occasions and it seemed to help him calm. Therefore the use of the soft helmet as proposed will serve a dual purpose. It will protect from injury when he actually engages in self-injurious behavior but it should also meet a sensory need that helps him calm. He is learning to wear the helmet to meet his sensory needs through a SEN IIP. **FADING PLAN:** When has went six consecutive months without requiring medical treatment for a head injury caused by SIB the IDT will consider discontinuing the soft helmet and trying to find a substitute such as a hat or cap.

- Psychotropic Medications - See attached addendum.
  Justification: Psychotropic Medications – Please see the attached Medication table, graph, and psychiatric and medical reports and or notes. There has been a med change and a med reduction this past year.

☐ **Less Restrictive Measures Tried or Considered:**

- is learning to accept a variety of sensory activities. He appears to like limited sensory items but seems to become overstimulated in his environment at times and becomes agitated. By introducing him to other sensory items that he might enjoy, he will have a better variety of items available and may be better able to engage in activities that will help him tolerate overstimulating environments.
- Tolerate and accept transitions
- To keep room organized and clean
- Complete a variety of activities throughout his day
- Massage therapy appointments weekly.
- Working with OT on different sensory items: weighted vest; swing; etc.

Dates	Medications	Average Daily Outburst		Comments
1/9/15 – 6/8/15	Celexa 15 Depakote 2000mg; Melatonin 1mg; Buspar 60	5.8	4.4	
6/9/15 – 8/31/15	Celexa 15 > 20 Depakote 2000mg; **Melatonin 1mg. > 0.5 mg. > 1.0 mg.** Buspar 60	6.0	6.7	6/9/15- Inc. Celexa to 20 mg. 7/1/15-Dec. Melatonin to 0.5 mg. 7/7/15-Start Naproxen 220 BID 7/8/15-Inc. Melatonin to 1 mg. 8/18/15-Start Ultram and DC Naproxen 8/27/15-Restart Naproxen 8/29/15-DC Ultram
9/1/15 – 12/31/15	Celexa 20 Depakote 2000mg; Melatonin 1mg; **Buspar 60 > 50**	6.3	6.1	12/24/16 – Decrease Buspar to 50 mg.
1/1/16 – 7/31/16	Celexa 20 Depakote 2000mg; Melatonin 1mg; Buspar 50	6.2	6.0	
8/1/16 – 10/31/16	Celexa 20 **Depakote 2000 mg. > 2500mg** Melatonin 1mg; Buspar 50	9.1	8.9	8/2/16 – Increase Depakote to 2500 mg. 11/28/16 – Increase Melatonin to 3 mg.
11/1/16 – 11/15/16	Celexa 20 **Depakote 2500 mg. > 2000mg** Melatonin 3mg; > 5 mg. Buspar 50	16.3	17.6	11/7/16 – Increase Melatonin to 5 mg. 11/15/16 – Decrease Depakote to 2000 mg.
11/16/16 – 12/5/16	Celexa 20 **Depakote 2000 mg.** Melatonin 5 mg. Buspar 50	17.4	17.7	
12/6/16 – 4/23/17	Celexa 20 **Depakote 2000 mg.** Ambien 10 mg Namenda 20 mg.	8.14	6.83	12/6/16-DC Melatonin and start Ambien 10 mg. 12/7/16-Decrease Buspar to 30 mg. and start Namenda 5 mg. 12/14/16- Decrease. Buspar to 15 mg. and increase Namenda to 10 mg. 12/21/16-DC Buspar and increase Namenda to 15 mg. 12/28/16-Increase Namen5da to 20 mg.
5/2017-7/2017	Celexa 20 **Depakote 2000 mg.** Ambien 10 mg Namenda 20 mg.	10.4	10.3	No med changes in 3 months. Downward trend noted for last 2 months in all areas.

Dates	Medications	Average EO	AGG	SIB	Comments
8/2017-11/2017	Celexa 20 **Depakote 2000 mg.** Ambien 10 mg.	255	1.75	176	12/2017 QPTRS Depakote ↓ to 1750

12/9/14	18	16	11	24	5	74
1/8/15	20	17	12	26	5	80
2/5/15	22	18	12	26	9	85
3/9/15	17	18	8	25	6	74
6/8/15						50
9/15/15	19	16	6	17	4	62
11/3/15	19	21	12	22	3	77
12/22/15	16	17	10	18	5	66
1/7/16	19	17	11	25	4	76
2/4/16	12	17	10	17	5	61
3/16/16	10	11	9	15	3	48
5/10/16	14	13	9	19	4	59
6/16						61
7/15/16	19	13	12	18	4	66
8/12/16	19	18	10	17	4	68
9/12/16	19	15	10	20	4	68
10/6/16	16	13	7	16	4	56
11/5/16	20	14	12	23	4	73
12/5/16	16	12	7	15	3	63
1/9/17	14	9	8	13	3	47
3/9/17	8	7	6	11	3	34
4/14/17	13	8	7	15	4	47
Date	Irritability	Lethargy	Stereotypy	Hyperactivity	Inappropriate Speech	Total
6/6/17	13	10	6	12	3	44
7/11/17	11	8	10	14	3	46
9/21/17	18	10	12	21	4	65
12/8/17	23	16	17	34	7	97
3/11/18	28	8	15	32	3	86
*6/25/18	21	20	9	27	0	77
8/16/18	37	23	20	39	11	130
9/11/18	31	6	14	35	10	96
12/6/18	20	23	12	29	0	84

*6/25/18 Data may still reflect the stress level on his side of the house due to a peer's struggle.
*9/11/18: Medical issues may have increased the scores. New ABC is coming for QPTRS in 12/2018.

WOODWARD RESOURCE CENTER
ANNUAL PSYCHIATRIC REVIEW

NAME: HOSP. NO.: ____   DATE: 6/26/2017

D.O.B.:   L.U.:   REFERRING PHYSICIAN: Dr. Horvath

CONSULTANT: Psychiatry

ANNUAL PSYCHIATRIC REVIEW

BACKGROUND HISTORY: is a 26-year-old male. was admitted to Woodward Resource Center on February 6, 2012. Records indicate that was originally diagnosed with autism at the age of 3. Starting in approximately November of 2010, began to have more challenges with agitated and aggressive behaviors. By March of 2011 his behaviors progressively had become more out of control culminating in an incident during which he hit his parents. After this incident he ended up being psychiatrically hospitalized at the University of Iowa. After hospitalization due to the severity of his ongoing symptoms, became more difficult to manage in an outpatient setting. This prompted his eventual admission to Woodward Resource Center. Primary documented psychiatric diagnoses at this time include autism spectrum disorder and severe intellectual disability. He also has a history of insomnia but his sleep has improved since starting treatment with Ambien. Challenging behaviors over the years have included significant aggression and SIBS. Previous psychotropic medication trials have included Geodon, lorazepam, trazodone, naltrexone and Inderal.

PSYCHOLOGY DATA/TEAM OBSERVATIONS: There was a slight upward trend in some of his behaviors during the spring of 2017. Team feels some of this may have been related to environmental stressors. On a positive note during this month of June so far, his behaviors appear to be improving.

RECENT LAB RESULTS AND HEALTH CONCERNS: From collection date of June 12, 2017, Depakote level 61.4, liver enzymes normal, platelet count 202,000, sodium level was normal at 140. There have been no recent acute health concerns of significance.

CURRENT PSYCHOTROPIC MEDICATIONS: Celexa 20 mg daily, Depakote 1000 mg b.i.d., Ambien 10 mg h.s., Namenda 10 mg b.i.d.

DRUG ALLERGIES: No known drug allergies, but historically it is noted that he may have had a paradoxical reaction to lorazepam in the past and he has responded poorly to certain types of psychotropic medications, such as several prescribing antipsychotic medications that have been used before. Finally, I am also told that he did not respond very well to trazodone in the past.

SIDE EFFECT RATING SCALES: On May 3, 2017, he scored 10 on a MOSES assessment.

PSYCHOTROPIC MEDICATION CHANGES MADE WITHIN THE PAST YEAR: Treatment with BuSpar was discontinued on December 15, 2016. Treatment with melatonin was also discontinued during the month of December 2016. Treatment with two new medications, Ambien, and Namenda, was initiated during the month of December 2016. Overall, has generally done better since the aforementioned medication changes were made.

MENTAL STATUS EXAM: During the appointment, was seated at the table accompanied by treatment team members. He was chewing on a bib and fidgety in his chair. is unable to directly answer many questions. He did say some of his usual phrases, such as repeating the two words "right now". Also he did make many of his typical vocalization. seemed to get bored with the appointment after a while and then stood up with staff to walk around the room. Mood varies, affect relatively calm at the day of appointment. No

obvious signs of overt psychosis. He is alert, not lethargic. At the time of the appointment, there were no immediate indicators of risk towards harm himself or others.

DIAGNOSES:

1. Insomnia by history, now well-controlled.
2. Autism spectrum disorder.
3. Severe intellectual disability.
4. Bilateral ceruminosis.
5. History of constipation.
6. Dry skin.
7. Possible TMJ dysfunction.

PLAN:

1. Neurology. None.
2. Dual Purpose Medication. None.
3. Psychotropic Polypharmacy. It is acknowledged that is being treated with the psychotropic polypharmacy regimen. Over a long-term basis, it is our goal to eventually get him down to the least amount of psychotropic medications that have been felt to be clinically necessary.
4. Intraclass Polypharmacy. None.
5. Psychotropic Medication Reduction Status. Most recent reduction was the discontinuation of treatment with BuSpar on December 15, 2016.
6. Psychiatric Follow Up. I will continue to see for ongoing psychiatric follow up.
7. Medical Follow Up. will continue to receive general medical care under the direction of Priya Philip, Physician's Assistant.
8. BSP. When talking about the Behavioral Support Plan, I was told that some positive programming changes may be in the works.
9. Psychotropic Medication Plan. Potential risks and benefits of psychotropic medications have again been carefully reviewed. had a rough spring of 2017, but things recently seem to be turning for the better. All things considered now is not considered to be the appropriate time to make a medication change of any type.

Matt Horvath, D.O.

Graph

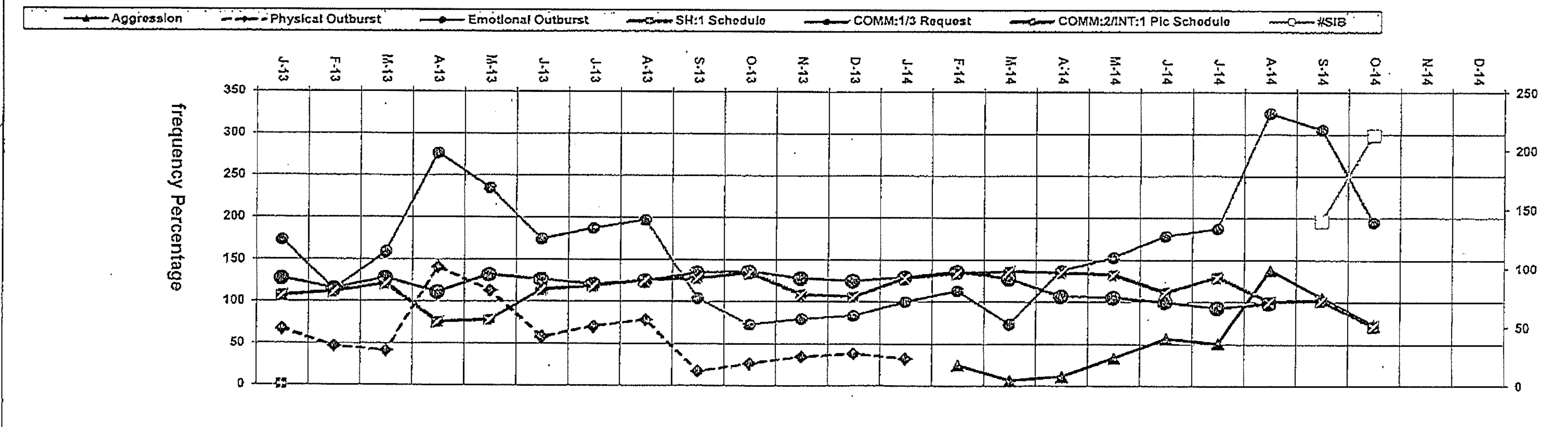
Name: | ID# | Address

target / index: Aggression — replacement: COMM:1/3 Request

target / index: Physical Outburst — replacement: COMM:2/INT:1 Pic Schedule

restrictive: Emotional Outburst — replacement: SH:1 Schedule

	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	MEAN
# Aggression														24	6	11	33	57	51	138	105	72			55.22
# Physical Outburst	67	47	41	141	113	58	70	78	17	26	34	38	32												58.62
# Emotional Outburst	173	114	159	276	235	174	187	197	104	72	79	83	100	113	73	138	153	178	187	325	306	195			164.59
#SIB																					140	214			
% COMM:1/3 Request	92	83	92	80	95	91	87	90	97	98	92	90	93	98	92	77	76	72	67	71					86.65
% COMM:2/INT:1 Pic Schedule	77	80	87	54	56	82	85	90	92	96	78	76	92	96	98	97	95	80	93	72	73	51			81.82
Life Changes: Psychotropic Medications: Celexa 20mg; Depakote 2000mg; Melatonin 10mg			COMM:1 dc'd-COMM:3 imp. to req snack; INT:1 obj met & rev.			COMM:3 rev. from verbal to gestural prompts	INT:1 rev to add gestural prompts		Melatonin dec. from 10 to 7.5mg on 10th		COMM:3 rev; INT:1 obj met & rev from 3 to 2 prompts	Melatonin dec. from 7.5 to 5mg on 12th; ISP on 16th		Physical Outburst dc'd; AGG +; COMM rev to 2G+2V prompt	COMM rev from 2G+2V to 1G+1V; INT rev from 2G+2V to 2V+1G	Melatonin dec from 5mg to 3mg on 3/11; Omega3 started on 4th		Melatonin decreased from 3mg to 1mg	BSP Rev & imp on 1st	8/4/14-Moved to 104 Cherry (Nov 303 Pine)	9/19-Start Buspar 15 mg. 9/26-Inc. Buspar to 30 mg.	Data thru 10/21 Oct 14 Buspar 40mg			
Sleep average hours per night	6.5	6.1	6.4	6.7	6.1	6.6	6.3	6.3	6.5	6.2	6.3	6.5	6.6	6.4	6	5.9	6.5	6.6	6.6	7.3	6.3	6.1			6.4
ABC Total Score	101		80								76	28		28	26	39	30	27	38		109	88			56



WOODWARD RESOURCE CENTER
Developmental Services

NAME		HOSP.		DATE:	9/30/15
ADDRESS		TEAM	2	BIRTHDATE	
EXAMINER	Linda Holl, PT	DEPARTMENT	Physical Therapy		

ANNUAL REVIEW/3-YEAR SCREENING

Medical History

Diagnoses: Autism spectrum disorder, insomnia disorder, severe intellectual disability, possible TMJ dysfunction, paradoxical bi-facial movements, and constipation.
Ophthalmology: Dr. Silbermann completed a limited exam on 2/12/14 due to minimal cooperation. He found eyes to be healthy and recommended follow-up in 1-2 years.
Audiology: According to testing results on 5/21/14, has overall hearing adequate for communication.
Neurology: Dr. Moore saw on 5/30/14 related to his paradoxical bi-facial movements.
ENT: Dr. Matthew Brown examined on 9/29/14 concerning possible TMJ dysfunction. He concluded that it is difficult to distinguish between his anxiety vs discomfort. A bite splint is not an option. He advised to continue Aleve 220 mg BID and Tylenol 650 mg prn for pain management.
Allergy: Dr. Jay Brown evaluated him on 10/31/14 for possible allergies. Skin tests for airborne allergens were all negative. The doctor advised no additional medications since he did not believe that self-injurious behavior was caused by undetected allergic sensitivities.
Psychiatry: receives citalopram (Celexa) 20 mg AM, diavalproex sodium (Depakote) 1000 mg AM & HS, buspirone (Buspar) 30 mg BID, and melatonin 1 mg HS for treatment of his autism spectrum and insomnia disorders. On 9/9/15, Dr. Horvath recommended no medication changes at his annual psychotropic review.

Risk Management Summary

is **high** risk for injury related to behavior (SIB) and **at-risk** for constipation. He is **not at-risk** for falls (9/30/15 professional review). He had only 1 recorded fall incident within the past 3 years; the fall on 5/5/13 was behavior-related and required no treatment.

Equipment

has a State twin bed with metal frame and 2 waterproof mattresses (no box springs).

Physical Therapy Assessment

demonstrates postural muscle tone, active extremity joint range of motion, and voluntary muscle strength all within functional limits for his daily routine. He has adequate arches such that he needs no special footwear. He stands with a forward head and mild out-toeing, but otherwise good posture. walks with a reciprocal pattern; heel strike is absent as he tends to walk on his toes. At slower walking speed, he demonstrates a toe-heel pattern. According to familiar staff, can safely manage stairs, curbs, ramps, and uneven ground. His weight is within the healthy range for his height.

Mobility & Transportation Summary

is independent in all position changes. He is a functional ambulator for all on-campus and community travel with staff supervision. He can access any available vehicle for transportation.

Recommendation

has fully functional mobility skills and is not at-risk for falls. He needs no physical therapy services at this time. He will be reassessed by PT in 3 years, according to the departmental policy. PT services are available in the interim by doctor's order or IDT request.

WOODWARD RESOURCE CENTER
COMPREHENSIVE PSYCHOLOGICAL ASSESSMENT

Name:		Date of Review:	9/1/16
Home:		Date Written:	8/25/16
WRC ID #:		State ID #	

- **Introduction:**
  - was born .
  - Strengths include being persistent.
  - Communicates by facial expressions, gesturing, and through the use of single words and occasionally two word utterances.

- **Medical and Social Family History:**
  - was born in Waterloo, Iowa, attended school in Ankeny, Iowa and lived with his parents in Bondurant, Iowa up until his placement at WRC.
  - parents are and . They reside in Bondurant, Iowa. has an older sister and brother. His older sister is married and lives in Ankeny. She visits infrequently. His older brother is in college and is home for breaks and during the summer and on an occasional weekend.
  - parents are his guardians.
  - does not have any known medical problems, but his parents state that he has not had a thorough medical exam for about eight years.
  - has a history of psychiatric and behavioral problems.

- **Current Behaviors of Concern:**

  Replacement Behaviors:
  - will independently follow a daily schedule.
  - Engage in Leisure Activities
  - will learn to engage in a variety of domestic chores.
  - Accept a variety of sensory activities.

  Precursor Behaviors:
  - Agitation: jumping, sweating , growling, making angry noises, making the statement that "you need to do that", slapping things, banging on items, flipping his items more rapidly than usual.

  Target Behaviors for Reduction:
  - Emotional Outburst: Dropping to the floor, throwing items, and/or breaking items.
  - Aggression: Hitting, slapping, kicking or pushing others.
  - Self-injurious behavior (SIB) includes slapping or hitting himself on the head/face or striking any body part against objects or surfaces with enough force to redden the skin.

Psychiatric Index Behaviors:

- Emotional Outburst (see definition above)
- Physical Outburst (see definition above)
- Self-injurious behavior (SIB) (see definition above)

- **Psychiatric Diagnoses:**

  Mental Health
  F51.01 Insomnia
  F84.0 Autism Spectrum Disorder
  Primary Diagnosis
  F72 Severe Intellectual Disability

- **Baseline and Treatment Data:**
  See attached graph

- **Summary of Previous Treatment:**
  - Prior to admission to WRC attempts were made by the family and The Homestead (SCL) to implement and use behavioral rehearsing scripts and picture communication systems. There is no data available to access his acquisition of these interventions or how these interventions impacted his behaviors, but there is antidotal information that . was able to use these types of systems at times to communicate his wants and needs. He came to WRC with a binder full of picture cards for daily living and hygiene.
  - 2/6/12 – initial BSP implemented based upon assessments and information provided by parents. Data collection on the target behavior of Outburst initiated.
  - 2/6/12 – LEIS:1 implemented to address history of not being willing to exit vehicles when reaching destinations.
  - 2/8/12 – SH:1 implemented to teach to independently follow a daily schedule.
  - 2/11/12 – COMM:1 implemented to teach . to use a picture communication system to request access to leisure items/activities with three of less verbal prompts.
  - 3/1/12 – LEIS:1 program discontinued due to success in exiting vehicles.
  - 3/3/12 – SH:1 revised due to meeting the programs previous objective.
  - 3/5/12 – BSP revised based upon the IDT discussion at his 30 day staffing.
  - 4/12/12 – Inderal increased from 80mg to 90mg, Depakote increased from 1250mg to 1500mg, and Ambien decreased from 10mg to 5mg a day following a visit with the Psychiatrist.
  - 4/26/12 – Inderal increased from 90mg to 100mg.

- 5/2/12 – Inderal increased from 100mg to 110mg, Depakote increased from 1500mg to 2000mg, and Ambien discontinued.
- 5/7/12 – COMM:1 program monitor increased the number of items that could request based upon input from direct care staff. No program revision was necessary for this addition.
- 5/15/12 – BSP revised to increase access to sensory items (flippers & chew tubes) throughout his day.
- 6/13/12 – Inderal taper to discontinuation initiated and concluded 14 days later.
- 6/28/12 – SH:1 recoded to COMM:2.
- 7/20/12 – BSP revised to change the target behavior from Outburst to Physical Outburst and Emotional Outburst. This was done to provide data about the intensity of outburst.
- 9/5/12 – COMM:1 program revised to allow to make a leisure item request verbally in addition to using a picture card.
- 9/20/12 – COMM:2 program revised and recoded to INT:1. The new procedures are attempting to teach to follow a printed daily schedule instead of a picture schedule.
- 10/2/12 – BSP revised to implement procedures for the NOC shift on how to support on nights that he is unable to sleep.
- 12/11/12 – INT:1 Objective met and the prompt level was decreased from 2 to 1 verbal/gestural prompt.
- 12/18/12 – COMM:1 revised to allow staff to provide verbal or gestural prompts.
- 2/6/13 – BSP revised. The revision included removing the need for to carry his own chew tubes as well as identifying additional ways to help calm down when he is upset.
- 2/28/13 – COMM:1 objective met, and the IDT determined that was now independent in requesting movies to watch.
- 3/1/13 – COMM:1 replaced by COMM:3. New program focuses on teaching Jared to appropriately request a snack.
- 3/16/13 – INT:1 program objective met and the program was revised to decrease prompt level.
- 4/19/13 – INT:1 program revised to address procedural problems.
- 5/22/13 – BSP updated to reflect new replacement programming.
- 6/18/13 – COMM:3 program met and revised to decrease prompt level from 3 verbal/gestural prompts to 3 gestural prompts.
- 7/18/13 – INT:1 program objective revised to better identify the use of verbal and gestural prompts.
- 9/26/13 – BSP revised to update the "Do this to Avoid Problems" section. The revised section included additional ways to help calm down and to redirect him back to appropriate activities.

- 11/25/13 – COMM:3 program met and revised to decrease prompt level from 3 gestural prompts to 2 gestural prompts.
- 11/26/13 – INT:1 program objective met and the program was revised to decrease the prompt level from 3 verbal and 3 gestural prompts to 2 verbal and 2 gestural prompts.
- 1/23/14 – 's BSP was revised, trained and implemented. Physical Outburst (BEH:2) was discontinued as a target behavior and aggression (BEH:4) was implemented.
- 4/5/14 – Fish Oil (Omega 3) was started in April at his guardian's request.
- 7/1/14 – BSP revised on 6/4/14 and is now implemented.
- 8/4/14 – moved to 303 Pine.
- 8/21/14 – Staff from 304 Pine retrained BSP because of increased rates of emotional outbursts, aggression and SIB and since then his rates are decreasing. A dosage of Flexaril that was prescribed for jaw pain was discontinued because of historical problems with this drug.
- 9/16/14 – Baseline for SIB (BEH:100) implemented. SIB will be used as an index measure to determine the effectiveness of his psychotropic medications.
- 9/19/14 – Buspar 15 mg. was started.
- 9/26/14 – Buspar dosage increased to 30 mg.
- 10/14/14 – Buspar dosage increased to 40 mg.
- 10/23/14 – EMOD: Locked plexiglas cover over TV (public) approved by HRC to protect the public TV at 303 Pine on the men's wing of the house.
- 10/27/14 – Omega-3 (fish oil) discontinued.
- 10/30/14 – EMOD: Padded bedroom walls and sharp corners in bedroom approved by HRC to protect from injury due to SIB.
- 11/5/14 – Baseline for SIB (BEH:100) was discontinued and an IIP for SIB (BEH:5) was implemented based on the results of baseline. SIB is being treated with an intergrated approach involving the assessment of medical, behavioral and psychiatric factors.
- 11/17/14 – Dr. Horvath decreased dosage of Celexa to 15 mg. and increased his dosage of Buspar to 60 mg.
- 12/10/14 – Decrease Celexa to 10 mg.
- 1/5/15 – Decrease Celexa to 5 mg.
- 1/9/15 – Increase Celexa to 15 mg.
- 1/13/15 – Start Tylenol QID.
- 2/27/15 – objectives for BEH: 3 (Emotional Outbursts) and BEH: 4 (Aggression) were both not met and were reset. went through a difficult transition when he moved to 'n early August of 2014 and may now be adapting to his new living situation and his rates may be decreasing. He is also on a daily dosage of Tylenol for pain and this appears to be helpful as well.

- 6/7/15 – Decrease Naproxen to 220 mg QD
- 6/9/15 – Increase Celexa to 20 mg.
- 6/18/15 – Increase Naproxen to 220 mg. BID
- 7/1/15 – Decrease Melatonin to 0.5 mg.
- 7/2/15 – Discontinue Naproxen 220 mg. BID and give Naproxen 220 mg. PRN
- 7/5/15 – Objective for BEH:5 (SIB) was met and reset. has made good progress although his rates are increasing over the past two months.
- 7/8/15 – Restore Melatonin dosage to 1.0 mg.
- 8/8/15 – Switch Naproxen to Ultram.
- 8/27/15 – Restart Naproxen 220 mg. BID.
- 8/29/15 – Discontinue Ultram.
- 11/5/14 – Baseline for SIB (BEH:100) was discontinued and an IIP for SIB (BEH:5) was implemented based on the results of baseline. SIB is being treated with an intergrated approach involving the assessment of medical, behavioral and psychiatric factors.
- 11/17/14 – Dr. Horvath decreased dosage of Celexa to 15 mg. and increased his dosage of Buspar to 60 mg.
- 12/10/14 – Decrease Celexa to 10 mg.
- 1/5/15 – Decrease Celexa to 5 mg.
- 1/9/15 – Increase Celexa to 15 mg.
- 1/13/15 – Start Tylenol QID.
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- 7/8/15 – Restore Melatonin dosage to 1.0 mg.
- 8/8/15 – Switch Naproxen to Ultram.
- 8/27/15 – Restart Naproxen 220 mg. BID.
- 8/29/15 – Discontinue Ultram.

- **Updates and changes over the past year:**
  - 11/19/15 – continues to exhibit an increased rate of injuries (mainly head injuries) that are a concern. With this in mind the IDT met today to discuss programmatic adjustments that could be helpful.. A number of suggestions are being followed up on that address the sensory function of SIB with compression clothing, trialing Bio-Freeze or a similar product, a trial of massage therapy and retraining of the use of his soft helmet. In November continues to exhibit substantially decreased rates of target behaviors but the IDT will be monitoring closely to determine the effectiveness of the aforementioned programmatic changes.
  - 12/24/15 – BSP modified to include that has a denim sensory vest with denim squares added to the front for him to grasp and Under Armour compression shirts that he is encouraged to wear and that he appears to prefer wearing.
  - 12/31/15 – objective for BEH:5 (SIB) was not met and reset. The objective was set for 2 months to make it come due at the same time as other objectives and to provide closer monitoring of SIB. Although his rates have been decreasing steadily and he very nearly met his behavioral objective he still has a substantial number of injuries from SIB.
  - 3/1/16 – objectives for BEH: 3 (Emotional Outbursts) and BEH: 4 (Aggression) and BEH:5 (SIB) not met and were reset. The IDT met on 11/19/15 to discuss programmatic adjustments that could be helpful.. A number of suggestions are being followed up on that address the sensory function of SIB with compression clothing, trialing Bio-Freeze or a similar product, a trial of massage therapy and retraining of the use of his soft helmet. By January exhibited decreased rates of target behaviors leading to one of his best months since he moved to . However, rates of all target behaviors are increased in February and SIB is substantially increased. Nonetheless did make progress in terms of reducing his average monthly rates of all target behaviors.
  - 3/2/16 – Following programmatic changes in late November and early December exhibited decreased rates of target behaviors. However, all increased in the latter half of the month and by the end of the month all rates had increased.. In January rates of all target behaviors substantially decreased indicating that recent programmatic interventions were effective, butin February rates of all target behaviors increased, especially SIB. The IDT discussed this today and feel that it is a problem with consistent program implementation. Retraining will be done and program monitoring will be increased to enhance the effectiveness of the aforementioned programmatic changes.
  - 3/23/16 – case was reviewed by Dr. Horvath at the QPTRs and he did not make any medication changes.
  - 6/23/16 – objectives for BEH: 3 (Emotional Outbursts) and BEH: 4 (Aggression) and BEH:5 (SIB) will not be met and were reset. The IDT met on 6/20/16 to discuss programmatic adjustments that might be helpful and concluded that rather than altering his programming it is best to retrain the procedures and make sure that all supplies are available to ensure consistency. After the current procedures were implemented in November of 2015

responded well but because of drift resulting from staff turnover and similar environmental issues there has been regression. Should this prove unsuccessful the IDT will consider consulting with the psychiatrist to explore psychotropic medication adjustments.

- 7/20/16 – BSP was modified to include procedures in the "Do This to Avoid Problems" section pertaining to traveling in a vehicle to prevent becoming aggressive towards others in the vehicle.
- 8/2/16 – was seen by Dr. Horvath for his annual psychiatric appointment and because of the upward trend in all of target behaviors despite several program modifications and retraining Dr. Horvath decided to increase his Depakote dosage to 2500 mg. from 2000 mg.

- **Diagnostic Assessments:**
  - The following Intellectual and Adaptive assessment information was provided by Duane Dolphin, Licensed Psychologist. Intellectual assessment was conducted at parents' house on February 2, 2012.

Intellectual functioning:

- On the Stanford-Binet Intelligence Scale – Fifth Edition, attained a Full Scale IQ score of approximately 40. He was only able to correctly complete a few of the testing tasks. He did not spontaneously name pictures and/or objects shown him, but said "bird", when shown the object and prompted by his father to say the word. When shown the figure of a cat, he again said "bird". tends to repeat or echo back what is said to him, but usually only the last word. He did show the ability to discriminate and match colors and objects. was able to place a circle, square and triangle into a form board, but was less apt to try to complete the task when shapes where in smaller component pieces. did not respond to the request to count, but tended to repeat some numbers when prompted to do so.

Adaptive functioning:

- The AAIDD **Adaptive Behavior Scale – Residential and Community: Second Edition (ABS-RC:2)** was completed by means of interview with parents and review of previous records. The ABS-RC:2 assessed adaptive skills across ten different areas. Those areas included Independent Functioning, Physical Development, Economic Activity, Language Development, Numbers and Time, Domestic Activity, Prevocational/Vocational Activity, Self-Direction, Responsibility and Socialization. attained Age Equivalent scores ranging from 3-years to 4-years on most domains, with the exception of his relatively higher score of 9-years on the Physical Development domain. He demonstrated significant limitation across all adaptive behavior domains. attained an overall Age-Equivalent score of 4-years-1-month, which translates into adaptive functioning within the **Severe** range of Mental Retardation/Intellectual Disability.
- Overall results of this assessment would indicate that intellectually, does function significantly below what would be expected of peers his age. He also demonstrates significant limitations in all adaptive behavior skill areas. does meet the essential criteria for a diagnosis of mental retardation according to DSM-IV guidelines. Results of this assessment would indicate intellectual

functioning within the **Severe** range of intellectual disability. currently demonstrates **Severe** deficits in adaptive behavior functioning. He will continue to require and benefit from extensive supports, services and supervision in all important life-skill areas.

- Previous records indicate that (13 years old) was administered an intellectual assessment on February 16, 2004. He was assessed through the use of the Stanford-Binet Intelligence Scale, Fourth Edition and a brief Adaptive Functioning Checklist. The results of that assessment placed intellectual abilities in the Severe Mental Retardation (318.1) range.
- A DASH-II (Diagnostic Assessment for the Severely Handicapped) was completed with the following results:

date	Impulse	Organic	Anxiety	Mood	Mania	PDD/Autism	Schizophrenia	Stereotypies
2/6/12	11/34	9/18	0/16	9/30	7/14	10/12	0/14	8/14
1/9/13	17/34	6/18	3/16	8/30	7/14	11/12	4/14	9/14
12/2/13	18/34	7/18	1/16	6/30	8/14	7/12	2/14	7/14
11/3/14	13/34	6/18	6/16	11/30	11/14	11/12	3/14	9/14
9/15/15	12/34	4/18	1/16	9/30	10/14	11/12	2/14	9/14
8/12/16	13/34	6/18	0/16	10/30	9/14	11/12	2/14	9/14

- The Aberrant Behavior Checklist was completed. The results are outlined in the table, below:

	Irritability	Lethargy	Stereotypy	Hyperactivity	Inappropriate Speech	Total
1/11/13	21	18	13	37	12	101
11/27/13	25	6	6	34	5	76
11/3/14	23	20	10	30	5	88
9/15/15	19	16	6	17	4	62
8/12/16	19	18	10	17	4	68

- **Preference Assessment:**
  - A *Reinforcer Assessment for Individuals with Severe Disabilities* (*RAISD*) completed on 8/12/16 and the following items and activities were identified as potential reinforcers: TV and Disney movies (Bambi, Winnie the Pooh, Little Mermaid); music (KIOA station, Candle in the Wind, Little Mermaid songs) Youtube and computer game. Food (pasta, Ramen noodles, peas, fish sticks, chips, bread and butter, peanut butter sandwiches, cereal, crackers, vanilla wafers, sweets, cake, Chinese food, tacos with sour cream, lettuce, Cheetos, Doritos) and milk. Foot rubs, being tickled, showers; stuffed animals (Winnie the Pooh, bunny); CD player, playing his keyboard; and going for van rides. He also seems to show some positive response to verbal praise (perhaps repeating some of his favorite phrases to him), pats on the back, hugs, clapping, pats on the back and especially shoulder and head rubs. He also now seems to enjoy occasionally looking at magazines, short walks, swinging for short periods of time and short van rides.

- **Behavioral assessment and Hypothesis:**
  - The *Questions About Behavioral Function (QABF)* was completed on 8/12/16. The functions of **Target Behaviors** are hypothesized to be:

Target Behavior	Primary Function	Secondary Function
Emotional Outbursts (EO)	Escape	Physical (Pain)
Aggression (AGG)	Escape	Physical (Pain)
Self-Injurious Behavior (SIB)	Escape	Physical (Pain)

  - The *Contextual Assessment Inventory* (*CAI*) was completed on 8/12/16. The results were as follows:

Target Behavior	Primary Context	Secondary Context
Emotional Outbursts (EO)	Possibly ill or in pain.	Disappointments and negative interactions with staff.
Aggression (AGG)	Possibly ill or in pain.	Uncomfortable environments (noisy). Factors related to tasks or activities. Transition Times and problems with his daily routine.
Self-Injurious Behavior (SIB)	Disappointments and negative interactions with staff.	Possibly ill or in pain. Uncomfortable environments (noisy). Factors related to tasks or activities. Transition Times and problems with his daily routine.

- assessment results tend to suggest that his emotional outbursts and aggression are maintained by a combination of social variables. Primarily physical pain and secondarily by escape. Hence, his programming will attempt to provide him more structure to his schedule and environment and improve his ability to communicate his wants and needs in an attempt to decrease the need for him to use emotional outbursts and aggression to escape unwanted or unexpected situations or to gain access to preferred items. He is also being closely monitored for symptoms of pain and analgesics are being prescribed as needed. The IDT has also been providing access to sensory items such as his vest, deep pressure and massage as a way of meeting his sensory needs and this appears to be helpful when implemented consistently.

- Contextual variables that were identified in the past to always precede target behaviors
  • Ongoing difficulty communicating wants or needs
  • Too many people around the person.
  • Inability to leave a setting.
  • Location associated with negative interactions
  • Failed to have his or her requests met.
  • Favorite activity ends.
  • Medical appointments or medical settings (having to wait for more than a few minutes for a medical appointment).

- , **Maintenance, generalization, and planning for the future:**
  - 's socially maintained target behaviors will be addressed through improving his ability to communicate his wants and needs and improving his ability to understand and participate in his daily routines. Structured teaching techniques are used in the development of his programming for his daily schedule/routine.
  - The IDT is providing access to sensory items such as his vest, compression wear, deep pressure and massage as a way of meeting sensory needs. This appears to be helpful when implemented consistently and should be continued.
  - The IDT and WRC psychiatrist continue to assess and adjust psychotropic medication regimen to best meet his needs. His current regimen of Celexa, Depakote, Melatonin and Buspar appear to be reasonably effective and have not been substantially modified over the past year while programmatic interventions have been made. In early August his dosage of Depakote was increased.
  - Pain management is an important component of plan of care and he is currently receiving a dosage of Naproxen for this. The IDT should continue to monitor his pain symptoms closely and adjust his medications accordingly.
  - has a history of disrupted sleep patterns that may affect his behavior and he currently receives a dosage of Melatonin as a sleep aid. Over the last three months has experienced fewer average hours of sleep per night and this should be closely monitored and assessed further if it persists.

Don Lehman, Psychology Assistant

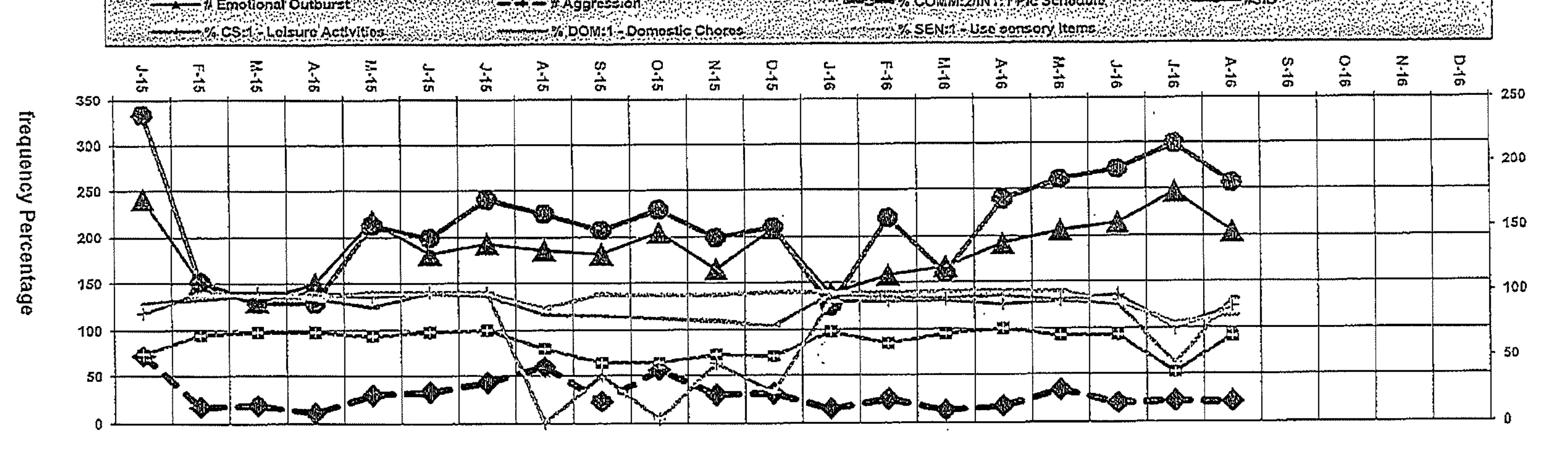
Jim Prickett, Psychology Administrator

Graph

Name: | ID# | Address

target / index: Aggression — replacement: COMM:1/3 Request | target / index: Physical Outburst — replacement: COMM:2/INT:1 Pic Schedule | restrictive: SIB — replacement: SH:1 Schedule

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	MEAN
# Emotional Outburst	242	151	131	150	218	182	193	186	182	205	165	209	138	158	167	192	206	214	247	204					
# Aggression	72	17	19	11	30	33	43	60	23	56	30	31	15	25	13	17	34	20	22	21					29.60
#SIB	238	108	92	92	152	142	172	161	148	164	142	150	89	157	114	171	186	194	214	183					
% COMM:2/INT:1 Pic Schedule	74	95	98	98	94	98	100	80	64	64	73	71	98	85	95	100	93	93	52	92					85.85
% CS:1 - Leisure Activities	84	100	100	100	97	100	100	0	36	3	45	23	93	93	94	90	93	97	71	88					
% DOM:1 - Domestic Chores	92	95	98	96	89	100	98	83	82	80	78	74	98	96	95	97	93	90	44	94					
% SEN:1 - Use sensory Items	X	98	98	97	100	100	100	88	99	98	98	100	100	99	100	100	100	92	75	81					
Life Changes: Psychotropic Medications as of 1/1/15: Celexa 20mg; Depakote 2000mg; Buspar 50 mg.	1/5-Dec. Celexa to 5 mg. 1/8-Inc. Celexa to 15 mg.	2/13-Start SEN:1				6/9-Inc. Celexa to 20 mg. 7/1-Dec. Melatonin to 0.5 mg.	7/7-Start Naproxen 220 BID 7/8-Inc. Melatonin to 1 mg.	8/18-Start Ultram and DC Naproxen 8/27-Restart Naproxen 8/29-DC Ultram			11/18-IDT added a number of sensory components to Jared's plan	12/9-Sensory components fully implemented. 12/24-Inc. Buspar to 60 mg.			3/2-Sensory procedures refreshed.				7/20-BSP modified to address safe vehicle travel.	8/2-Inc. Depakote to 2500 mg. Data thru 8/25/16					
Sleep average hours per night	5.6	5.6	6	6.6	6.2	6	6.1	6.3	5.7	5.9	6.1	4.6	5.1	4.7	5.5	6	5.6	4.9	4	4.8					5.6
ABC Total Score	80	85	74			50			62	58	77	66	76	61	48		59	61	66	68					66



Social Service Report

County of Residence: Polk
Date of Annual Meeting: September 1, 2016

Referral Information:
Information for this report was obtained from professional reports in addition to verbal information provided by parents throughout the Diagnostic Evaluation process. was transported to the Woodward Resource Center campus by his parents, had lived at his family home since birth. 's parents reported that they started seeing significant behavioral changes with around November 2010. started refusing to get out of the van to go into school. Multiple attempts were made to assist in getting to school, however none of them were successful. was reported to have increasing agitation which included: ear slapping, yelling, running up and down stairs and hitting walls, doors and windows, throwing himself to the floor. parents reported that was rarely aggressive toward others; however they saw occasional aggression when a caregiver attempted to intervene when was engaging in self-injurious behaviors. parents also reported that had not been sleeping well and had a substantial weight loss. was becoming increasingly agitated by noises in the home. He was bothered by the toilet flushing, sound of water in pipes when people are taking showers, people talking, other's coughing. s parents did attempt to find a community placement for ; however, providers either did not feel that they could provide the supports that would need or they did not have openings at that time.

Legal Status:
is a voluntary admission to Woodward Resource Center. were appointed as Co-Guardians for on March 10, 2009. were divorced on February 12, 2015. ther became his legal guardian on 5/5/15. continues to receive monthly/quarterly updates and a copy of 's ISP. He may call the Social Worker for updates and he continues to see when he can.

Residential, Service and Evaluation History:
has lived with his parents since birth. The following services were provided to while living with his family.

Respite Service, Supported Community Living (SCL) Homestead: January of 1988 to October of 2015
Respite Services, SCL Respite Connections: June of 2008 to October of 2015
Respite Services, Lutheran Services: February of 1995 to November of 1995
SCL Services, Lutheran Services: December of 1995 to July of 2010
Intellectual Disability Waiver Services, Hawkeye Health: March of 1996 to March of 2000
saw Dr. Took for ongoing Psychiatric Services

was hospitalized at the University of Iowa Hospitals and Clinics Adult Psychiatric Unit on 3/12/11 and was discharged on 3/21/11.

Significant Physical and Mental Health Conditions History:
Reports indicate that was diagnosed with Autism and an Intellectual Disability (Mental Retardation) in early childhood. Parents report the Autism diagnosis was made at age 3 1/2. began receiving special education services through the Ankeny school system at that time. was seen in Iowa City for a consult around the age of 5 yrs. was again seen at Iowa City for a consult in February of 2011. A Psychological Evaluation was completed on 2/16/04 through Broadlawns in Des Moines. was diagnosed with Severe Intellectual Disability (Mental Retardation).

parents report that had tubes placed in his ears around age 2 or 3. has also had severe sinusitis and at one point was hospitalized for two days for treatment of the sinusitis. When was hospitalized at the University of Iowa Hospitals and Clinics Adult Psychiatric Unit they were able to get an abdominal x-ray which showed constipation.

Substance Abuse History:
None reported.

Work/Academic History:
attended school in the Ankeny Special Education system from the time he 3 ½ years of age through the age of 19.

Family and Developmental History:
was born to and on February 11, 1991 in Waterloo, Iowa. was born at 37 weeks gestation following an uncomplicated pregnancy. and his family lived in Cedar Falls until was around 2 ½ years old. family then moved to Ankeny. and his family then moved to Bondurant where they have resided for the last 10 years. and were divorced on February 12, 2015. has remarried and moved out of state. He continues to receive monthly/quarterly reports and visits as he can.

has one sister, who is married and resides in Ankeny. also has a brother, who is currently living at home.

Abuse History:
None reported.

Significant Relationships:
Important relationships for include his parents and siblings. also has the support of a maternal grandmother and aunt who live in Waterloo. enjoyed spending time at his grandmother's house when he was younger. family visits him on the WRC campus weekly. father has moved out of state, he continues to receive information on

Financial Information:
receives SSI benefits. WRC is the representative payee for those benefits. qualifies for Medicaid benefits to cover his care and medical expenses. also has private insurance through his parents to assist with payment of medical and dental expenses. has $952.75 in his WRC personal spending account as of 8/9/16. has been assigned to the United Health Managed Care Organization (MCO) for Case Management of his Title XIX benefits/services.

Current Information:

resides at with twelve male peers. attends vocational training at the Westwood building on campus. remains on the waiting list for services at the Homestead, Mosaic and REM. A referral was made to the Money Follows the Person Grant Program. Cindy Pauk has been assigned as the Transition Specialist for moved from to on August 4, 2014. He currently lives with 5 male peers and 5 female peers. He now attends vocational training at the Larches building on campus. continues to remain on the waiting list for services at the Homestead and Opportunity Village.

Expected Outcome of WRC Treatment/Future Plan:

will move to a community placement in the Central Iowa area.

Recommendations:

- Continue to keep in contact with mother/guardian giving her updates on status as requested as well as provide her with monthly/quarterly reports.
- Continue to provide father with updates as requested as well as send him monthly/quarterly reports.
- Continue to provide UnitedHealth Case Manager with updates as requested as well as send monthly/quarterly reports.
- Please see Future Vision/Discharge Plan.

Terri Hudson, LBSW 8/11/16
Social Worker II

Visit Summary

Visit Information

	Provider	Department
3/12/2011 9:48 AM	Yelena Chistyakova, MD	1jpw

H&P signed by Siddharth Bajpai, MD at 03/28/11 0834

Author:	Siddharth Bajpai, MD	Service:	PSY ADULT PSYCHIATRY	Author Type: Physician-Resident	
Filed:	03/28/11 0834	Note Time:	03/12/11 1128	Cosign Required:	Yes
Trans ID:	Unknown	Trans Status:	Unknown		

Psychiatric History and Physical

Admit Date: 3/12/2011
Name:
MRN:
DOB:

Chief Complaint: worsening aggressive behaviors.

HPI:
During the interview, the patient was in restraints and intermittently agitated. His mother, ( ), who is also his legal guardian, told me that " , was diagnosed as being autistic when he was 3. He speak a few words, but the main mode of communication is nonverbal (through pictures, writing words, etc). Since last November, he has been having more frequent episodes of agitation, has trouble going to school. Last night, he started hitting himself, was slamming the furniture in his room". Last night he charged at his parents and hit them. Parents were able to calm him down, took him to the ETC of an outside hospital, where he got agitated again (was given 15 mg IV Haldol, Ativan and propofol). Was accepted for transfer to a hospital. The patient was brought to the UIHC ETC in an ambulance. Morning labs were done in the ETC, the patient was felt to be medically stable for transfer to 1 JP West. Parents deny any recent changes in his schedule, home environment, or caregivers that could have triggered these behaviors. Mother denied a history of suicidal thoughts. Did acknowledge having "lots" of self-harm behaviors saying, "he hits himself hard, punches himself when he is upset." Parents denied knowledge of the patient having experienced auditory or visual hallucinations.

Per Dr Dr Falcon's transfer note dated 2/12:
Received a call from Dr. Lynn Smith at Mercy hospital in Des Moines requesting transfer of this patient. He was brought into the ER by his parents after waking up at 3:30 AM today and running up in the down the stairs, yelling, and hitting walls and doors. He reportedly has a history of autism and has had increasing episodes of agitation over the last 4 months, poorly controlled with his medications. Apparently he hit his mother recently and parents are feeling like they cannot control him and protect themselves. He sees a psychiatrist locally in Des Moines and attempts have been made at medication adjustment without success. His parents have been attempting to get him in to be seen by CDD here for management but have not yet been in for an appointment. Past medication trials include Geodon and risperidone, both of which caused "inappropriate muscle movements" and were discontinued. Other psychiatric diagnoses were not known by Dr. Smith.
Current meds:
Ativan 2 TID

guanfecine 1 mg TID
Trazodone 50 mg tabs 1-2 tabs PO q HS
Ambien 10 mg q HS
Melatonin (dose unknown)
Past medical history: none
He was very agitated on presentation to the ER and required 5 mg of Haldol + 2 mg of Ativan, another 5 of Haldol + 1 of Ativan, another 5 of Haldol, 5 of Versed, and then eventually propofol over the last 3 hours to sedate him enough to draw labs. CBC, BMP, urinalysis, TSH were reported to be within normal limits. Urine drug screen was positive only for benzodiazepines. EKG was negative per report. Most recent vitals were T: 98F, P 55, R 15, BP 101/55, O2 sat 100%.
Dr. Smith reported the mother would come with him to the ER and that they planned to transfer him by ambulance. I informed her I will accept this patient for transfer as we do have a bed available. I did tell Dr. Smith that the mother must provide the paperwork showing she is his legal guardian when he comes to our ETC and signs him in, or, if this is not possible, Dr. Smith must obtain an emergency hold on the patient prior to the transfer. She acknowledged this and say she would do one of those two things and stated she would send with the patient copies of lab work, EKG, and ER documentation as well as the guardian paperwork or the emergency hold documentation.

PAST PSYCHIATRIC HISTORY:

Diagnosed as having "autism and mental retardation in his childhood." Currently follows up with Dr. Kevin Took in Des Moines, is currently on Ativan 2 mg TID, was started on Tenex 1 mg TID about 2 weeks back, is also on trazodone 50-100 mg qhs for insomnia, as well as an Ambien 10 mg qhs for insomnia. He is compliant on these medications, "if we crush the medicines in the food that he is going to receive. He does not swallow any tablets if they are given to him." Parents deny a past history of suicide attempts. Parents denied a past history of psychiatric hospitalizations.

FAMILY HISTORY:

Maternal uncle had a history of schizophrenia. Parents denied a family history of mental retardation or autism.

SOCIAL HISTORY:

He is single, lives with his parents, was attending Ankeny High School until 11/2010, was in special education there. Since then, spends the whole day watching TV and on the computer. Parents deny a past history of pending legal issues. Deny a past history of cigarette smoking, alcohol consumption, or recreational drug abuse. The patient is not toilet trained, wears diapers.

PAST MEDICAL HISTORY:

Parents deny any current significant medical issues.

Past Surgical History:

No past surgical history on file.

Medications at Admission:

Prior to Admission medications

Medication	Sig	Start Date	End Date	Taking?	Authorizing Provider
amphetamine-dextroamphetamine (ADDERALL) 5 mg tablet	Take 5 mg by mouth daily. Take 2 twice daily for 2 weeks then 3 daily				Patient Reported
LORAZEPAM PO	Take by mouth.				Patient Reported
traZODone (DESYREL) 50 mg tablet	Take 50 mg by mouth at bedtime. Takes				Patient Reported

were discontinued. Other psychiatric diagnoses were not known by Dr. Smith.
Current meds:
Ativan 2 TID
guanfecine 1 mg TID
Trazodone 50 mg tabs 1-2 tabs PO q HS
Ambien 10 mg q HS
Melatonin (dose unknown)
Past medical history: none
He was very agitated on presentation to the ER and required 5 mg of Haldol + 2 mg of Ativan, another 5 of Haldol + 1 of Ativan, another 5 of Haldol, 5 of Versed, and then eventually propofol over the last 3 hours to sedate him enough to draw labs. CBC, BMP, urinalysis, TSH were reported to be within normal limits. Urine drug screen was positive only for benzodiazepines. EKG was negative per report. Most recent vitals were T: 98F, P 55, R 15, BP 101/55, O2 sat 100%.
Dr. Smith reported the mother would come with him to the ER and that they planned to transfer him by ambulance. I informed her I will accept this patient for transfer as we do have a bed available. I did tell Dr. Smith that the mother must provide the paperwork showing she is his legal guardian when he comes to our ETC and signs him in, or, if this is not possible, Dr. Smith must obtain an emergency hold on the patient prior to the transfer. She acknowledged this and say she would do one of those two things and stated she would send with the patient copies of lab work, EKG, and ER documentation as well as the guardian paperwork or the emergency hold documentation.

Addendum at 1jpw: Mother reports that he always slaps his ears when he is not in good mood. This behavior has presented for long time and worsen for a year. Recently, it occurs 2-4 episodes/day, last 5-30 minutes/each episode. Family usually distracts him by putting something on his hand, or open Disney DVD for him. He has been in special class in high school until last November, he suddenly stopped going to school and deteriorated since then. He needs redirection and 1:1 both at school and home. He is dependent for self care. They has been dealing with worsening behavior since November last year. They tries to find some placement for him, but failed. He has never been on Depakote. Mother concerns with blood monitoring if he is on Depakote. He has been on several antipsychotics including Abilify, Risperdal, Geodon, Seroquel. His psychiatrist is Dr. Took at Lutheran Hospital in Des Moines.

Past Psychiatric History:
Per H&P on 3/12/11
Diagnosed as having "autism and mental retardation in his childhood." Currently follows up with Dr. Kevin Took in Des Moines, is currently on Ativan 2 mg TID, was started on Tenex 1 mg TID about 2 weeks back, is also on trazodone 50-100 mg qhs for insomnia, as well as an Ambien 10 mg qhs for insomnia. He is compliant on these medications, "if we crush the medicines in the food that he is going to receive. He does not swallow any tablets if they are given to him." Parents deny a past history of suicide attempts. Parents denied a past history of psychiatric hospitalizations.

Past Medical History:
Per H&P on 3/12/11
-Parents deny any current significant medical issues.
-No past surgical history

Medications on Admission:
Prior to Admission medications

Medication	Sig	Start Date	End Date	Taking?	Authorizing Provider
guanFACINE (TENEX) 1 mg tablet	Take 1 mg by mouth 2 times daily.			Yes	Patient Reported
LORazepam (ATIVAN) 2 mg tablet	Take 2 mg by mouth 3 times daily.			Yes	Patient Reported

MELATONIN PO	Take 10 mg by mouth at bedtime.	Yes	Patient Reported
traZODone (DESYREL) 50 mg tablet	Take 50-100 mg by mouth at bedtime.	Yes	Patient Reported
zolpiDEM (AMBIEN) 10 mg tablet	Take 10 mg by mouth at bedtime as needed.	Yes	Patient Reported

Family History:
Per H&P on 3/12/11
Maternal uncle had a history of schizophrenia. Parents denied a family history of mental retardation or autism.

Social History:
Per H&P on 3/12/11
He is single, lives with his parents, was attending Ankeny High School until 11/2010, was in special education there. Since then, spends the whole day watching TV and on the computer. Parents deny a past history of pending legal issues. Deny a past history of cigarette smoking, alcohol consumption, or recreational drug abuse. The patient is not toilet trained, wears diapers.

Hospital Course:
20 year old male with diagnoses of autism and mental retardation per his parents presenting with increasing physically aggressive behaviors toward his mother at home for the last 4 months. It got worse before admission and parents could not manage patient at home at that time . Outpatient psychiatrist in Des Moines attempted to adjust medications with little success in controlling behavior. The patient was tried on Geodon and Risperdal, both of which caused "inappropriate muscle movements" and were thus discontinued. He came as a transfer from Mercy Des Moines after presenting to that ER and was given haldol, ativan, Versed, and finally Propofol in their ER to calm him enough to get labs. EKG was ok. He was reported to be stable at time of transfer. He has no known medical problems. His mother who is his guardian signed for voluntary admission. He was placed on violence and self harm precaution with restricted activity level. Has been in restraints since arrival due to agitation. He was more redirectable enough to be out of restraint in low stimulation environment (seclusion room). His outpatient medications were restarted: Ativan 2 mg tid, Trazodone 50 mg hs, Ambien 10 mg prn insomnia. Labs including liver function test were normal. He has been constipated for at least a week. Abdominal X-ray showed moderate amount of stool in colon. Simethicone 80 mg tid and Senokot 8.6 mg bid started on 3/15/11. Depakote sprinkle (he refused Depakene due to its taste) was started and titrated up to 1500 mg/day on 3/17/11. Depakote level on 3/21/11 was 91.5. LFTs were normal. He had blood test for Fragile-X syndrome obtained since family would like to know this information for patient's brother and sister, result pending. CDD consulted and started working with family for behavior management. Per CDD, his ritualistic behavior with computer is very severe and beyond a level of autistic behavior. Obsessive/compulsive symptoms needs to be observed, and ruled out. We did not start any medications for OCD during this admission. Patient has been calmer, more communicative, and compliant with medications. He has no longer exhibited aggressive or self harm behavior like banging on his ears. Family meeting performed on 3/21/11, they were agreeable with plan to discharge him back home. They are in process of finding a placement for him.

Diagnosis:
Axis I: Autistic Disorder 299.00. Rule out Obsessive-compulsive disorder.
Axis II: Mental Retardation most likely moderate to severe.
Axis III: Constipation
Axis IV: Moderate, Problems related to social environment, chronic mental illness.
Axis V: Global assessment of functioning (GAF): 10

no evidence Hx fragile X

Mental Status Exam:

Appearance: disheveled
Psychomotor: intermittently somewhat agitated
Behavior: unable or unwilling to cooperate with interview
Speech/language: incoherent speech, mostly just repeating vowels and sounds
Mood: Unable to assess
Affect: Increase in intensity and range
Thought Process: Unable to assess
Thought Content: Unable to assess
Orientation: Unable to assess
Insight: Appears poor
Judgment: Poor
Estimate of Intelligence: Below average
Gait and Station: Not tested

Suicide Risk Screening:
Suicide risk screening was done with no positive results requiring action.

Condition on Discharge:
He is calmer, and more cooperative with nursing care. He does not exhibit aggressive, agitated, or self injurious behavior. He is taking his medications with milk or peanut butter sandwich. Constipation has resolved.

Instructions Physical Activity:
-as tolerated

Medications on Discharge:

Home Medication Instructions

Printed on:03/21/11 1630

Medication Information								
LORazepam (ATIVAN) 2 mg tablet Take 2 mg by mouth 3 times daily.								
traZODone (DESYREL) 50 mg tablet Take 50-100 mg by mouth at bedtime.								
sennosides (SENOKOT) 8.6 mg tablet Take 1 Tab by mouth daily. Crush and sprinkle on food Indications: Constipation								
divalproex (DEPAKOTE SPRINKLES) 125 mg capsule Take 6 Caps by mouth 2 times daily. Med may be Swallowed Whole or Sprinkled on Soft Food Indications: autism								
Simethicone 80 mg Tab Take 80 mg by mouth 3 times daily. Indications: Flatulence								

Diet: Regular Diet

Follow-Up Instructions:
-Psych outpatient appointment with Dr. Took at Lutheran hospital in Des Moines on 4/1/11
-monitor LFTs, lipid profile 1-2 time/year. May obtain blood when he has annual dental check
-CDD suspected for OCD. May need to observe his ritualistic behavior that it is at the level of obsession/compulsion or not.
-CDD will continue working with family and school for behavioral management
-family and SW is in process of finding a facility for him in future

Discharge Provider:
Dr. Took at Lutheran hospital in Des Moines, IA

Legal Status: Voluntary per DPOA

Other:
-need to be compliant with medications
-contact hospital if he is more combative, aggression
-monitor signs of Depakote toxicity such as severe nausea/vomiting, abdominal pain, jaundice

Paul Thisayakorn, MD

Revision history:

> 03/21/11 2234 D/C Summaries Signed By Yelena V Chistyakova, MD
03/21/11 1836 D/C Summaries Signed by: Paul Thisayakorn, MD

#3 Brief Summary of Data or Scientific Evidence Supporting Action

In a recent petition to add Autism to Minnesota's Medical Cannabis Program, one petitioner provided the following when addressing the issue of the availability of conventional medical therapies in the treatment of autism.

> While professional and scientific debate continues regarding the specific causes of autism, research has shown that irrespective of the causes ASD patients often suffer from painful chronic inflammation, particularly in the brain and in the digestive tract. Additionally, researchers studying brains affected by ASD found a common pattern: widespread activation of brain immune cells that produce inflammation.[1] Chronic inflammation in the brain has been shown to lead to encephalitis—an acute inflammation (swelling) of the brain usually resulting from either a viral infection or due to the body's own immune system mistakenly attacking brain tissue.[2] Additionally chronic inflammation in the digestive tract is a known factor behind many of the challenging GI disorders ASD patients may experience.[3]

In making the argument that medical cannabis could benefit persons with ASD, the petitioner provided the following summary on the medical research thus far.

> Clinical research regarding the therapeutic benefits of cannabis has been almost nonexistent in the United States since cannabis was given Schedule I status in the Controlled Substances Act of 1970. Despite this challenging research environment, some research has been or is being conducted demonstrating the positive

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[1]Simone Gupta, et al., *Transcriptome Analysis Reveals Dysregulation of Innate Immune Response Genes and Neuronal Activity-Dependent Genes in Autism,* Nature Communications (Dec. 2004), https://www.nature.com/articles/ncomms6748.

[2]Janet K. Kern, et al., *Relevance of Neuroinflammation and Encephalitis in Autism,* Frontiers in Cellular Neuroscience (Jan. 2016), https://www. Ncbi.nlm.nih.gov/pmc/articles/PMC4717322/.

[3]Finale Doshi-Velez et. Al, *Prevalence of Inflammatory Bowel Disease Among Patients with Autism Spectrum Disorders,* Inflammatory Bowel Diseases (Oct. 2015), https://academic.oup.com/ibdjournal/article-abstract/21/10/2281/4644914?redirectedFrom=fulltext.

effects of cannabis on ASD patients or on non-ASD patients who share common symptoms with ASD patients. . . .

Research-Supported Symptoms Improvements

In 2013, a study[4] published in the journal Neuron revealed that autism-related mutations in mice resulted in "deficits in endocannabidoid signaling." The study concluded that "alterations in endocannabinoid signaling may contribute to autism pathophysiology." Also in 2013, researchers at Stanford University found that the symptoms of autism are caused by a mutation in the neurologin-3 gene that both blocks the body's natural production of endocannabinoids and also interferes with the way cannabinoids communicate with the brain. Cannabinoids in cannabis interact with the body's endocannabinoid system and act not only to regulate emotion and focus but also serve as a neuroprotectant preventing further degradation of brain cells.[5] Researchers at the University of Irvine in California believe they have also discovered a link between endocannabinoids and ASD, concluding that "increasing natural marijuana-like chemicals in the brain can help correct behavioral issues related to Fragile X syndrome, the most common known genetic cause of autism."[6]

Yet another study[7] from 2013 that was published in the Journal of Autism and Developmental Disorders revealed a link between the endocannabinoid system and immune cells in children with autism. Because immune dysfunction is a factor that

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[4]Csaba Foldy, et. al, *Autism-Associated Neuroligin-3 Mutations Commonly Disrupt Tonic Endocannabinoid Signaling*, Neuron (May 8, 2013), https://www.ncbi.nlm.nih.gov/pubmed/23585028.

[5]E. de Lago and J. Fernandez-Ruiz, *Cannabinoids and Neuroprotection in Motor-Related Disorders*, https://www.ncbi.nlm.nih.gov/pubmed/18220777.

[6]*Boosting Natural Marijuana-Like Brain Chemical Treats Fragile X Syndrome Symptoms*, https://news.uci.edu/press-releases/boosting-natural-marijuana-like-brain-chemicals-treats-fragile-x-syndrome-symptoms/

[7]D. Siniscalco, et.al, *Cannabinoid Receptor Type 2, But Not Type 1, Is Up-regulated in Peripheral Blood Mononuclear Cells of Children Affected By Autistic Disorders*, Journal Autism Developmental Disorder (Nov. 2013)[hereinafter Siniscalco], https://www.ncbi.nlm.nih.gov/pubmed/23585028.

contributes to autism, the condition is believed to be linked to higher levels of CB2 receptors in cells (CB1 receptors, on the contrary, were not overexpressed). CB2 receptors play a significant role in regulation of the immune system. Because problems with the immune system are so closely related to autism, the authors of the study concluded that the use of cannabinoids and therapies that target CB2 receptors might be helpful for those who suffer from ASD.

As already addressed in my letter to the Cannabidiol Board, research also suggests that medical cannabidiol may be beneficial in treating some of the other condition autistic persons are prone to including gastrointestinal problems and the pain associated with. Moreover, the Autism Research Institute believes that many symptoms of autism can be mitigated through the use of properly titrated (dosed) cannabis:

> Some of the symptoms medical marijuana has ameliorated include: Anxiety—even severe anxiety—aggression, panic disorder, generalized rage, tantrums, property destruction, and self-injurious behavior.

It is undisputed that much more research needs to be done on the effects of medical cannabidiol on the symptoms and treatment of autism. A recent retrospective study conducted in Israel involved sixty children with ASD.[8] The study assessed safety, tolerability and efficacy of CBD based medical cannabis, as an adjuvant therapy, for refractory behavioral problems in children with ASD. The children were treated with oral CBD and THC at a ratio of 20:1. The dose was up-titrated to effect with the maximal CBD dose 10mg/kg/d. Following the cannabis treatment, 61% of the patients had improvements in behavioral outbreaks, 39% and 47% had improvements in anxiety and communication problems respectively, and 29% reported improvement in disruptive behaviors. There were also reports of lesser improvements in sleep disturbances, irritability and loss of appetite. This study has led to "the first clinical trial in the world to test the benefits of medicinal marijuana for your people with autism."[9] This

[8]Adi Aran, et al., *Cannabidiol Based Medical Cannabis in Children with Autism—a Retrospective Feasibility Study*, Neurology (April 24, 2018).

[9]*Marijuana May Be a Miracle Treatment for Children with Autism*, USA Today (www.usatoday.com/story/news/world/04/25/marijuana-pot-treatment-children-autism-cannabis-oil/100381156/.

study, conducted in Israel, involved 120 children and young adults, ages 5 to 29, who have mild to severe autism, and lasted through the end of 2018. As of yet, no report has been released.

In another study, researchers at the University of California San Diego School of Medicine will be investigating whether CBD safely and effectively provides therapeutic benefit for ASD's more problematic symptoms such as aggressive behaviors, repetitive or self-injurious behaviors, hyperactivity and social and communicative deficits.[10] According to the director of the school's Center for Medicinal Cannabis Research, Dr. Igor Grant, "accumulating evidence suggests the endocannabinoid system is associated with four phenotypic features known to be atypical in ASD: social reward responsivity, neural development, circadian rhythm and anxiety-related symptoms, and [t]hat makes the endocannabinoid system a prime region for finding and testing new, potentially therapeutic compounds, such as CBD."

Along with the research available, there are numerous anecdotal reports of symptom improvements. Rather than repeat these stories, they are included in the articles and literature attached. In view of the limited research, the very serious symptoms that persons with ASD may exhibit, and the limited success with current recognized treatments and drug therapies, anecdotal evidence should not be dismissed.

[10] Gabrielle Johnston & Scott LaFee, *Is CBD a Remedy for Autism? TBD*, UC San Diego News Center (Apr. 26, 2018), https://ucsdnews.ucsd.edu/feature/is-cbd-a-remedy-for-autis-tbd.

response to conventional treatments and chronic intractable pain. Disease activity before and after cannabis use was estimated using the Harvey-Bradshaw index for Crohn's disease, and patients assessed their general medical well-being before and after use. Patients' hospital records were obtained to monitor disease activity, rate of hospital admission, use of additional drugs, and need for surgical intervention. All 30 patients rated their general medical well-being as improved after cannabis use via a visual analog scale. Twenty-one patients had a notable improvement after treatment with cannabis use. Only 2 patients required surgery during a period of 3 years of cannabis use, a rate that Naftali and colleagues claimed is a significant improvement for the normal operative rate in patients with Crohn's disease. Whereas 26 patients required corticosteroid therapy prior to cannabis use, only 4 patients were still maintained on corticosteroids after cannabis use, suggesting a possible corticosteroid-sparing effect of cannabis. There was also a substantial drop in use of aminosalicylates, thiopurines, methotrexate, and tumor necrosis factor antagonists. The authors cited these data as objective benefits of cannabis use and advocated for more placebo-controlled studies for further evaluation of therapeutic effects of cannabis use.

In 2017, the National Academies of Sciences, Engineering and Medicine published its findings on the health benefits of medical cannabis entitled "The Health Effects of Cannabis and Cannabinoids"[23]. While not specifically focused on ASD patients, a notable finding from this research is that in adults with chronic pain, patients who were treated with cannabis or cannabinoids are more likely to experience a clinically significant reduction in pain symptoms.

Anecdotal Symptom Improvements

Anecdotal reports of symptom improvements due to medical cannabis are primarily sourced from ASD patients and caregivers. Medical cannabis can help to relieve many symptoms commonly associated with ASD, including but not limited to anxiety, aggression, panic disorder, generalized rage, tantrums, property destruction and self-injurious behavior[24]. Here we will highlight a portion of the parent testimony of Victoria Grancarich, whose son Julian qualified for medical cannabis based on his history of seizure disorder:

> *Julian had always been a kind and affectionate boy in his younger years. When Julian turned 13, the onset of puberty brought new challenges. In February of 2016 Julian became extremely violent toward both family and school staff. In August 2016, Julian began to turn the violence on to himself.*

[23] https://www.ncbi.nlm.nih.gov/books/NBK423845/pdf/Bookshelf_NBK423845.pdf
[24] https://www.massroots.com/learn/cannabis-treatment-autism

He began punching himself in the head [and] would use his knee to injure his teeth. He would bang his head into walls. Between October 2016 and January 2017, Julian was hospitalized 3 times. He suffered self-inflicted skull fractures and massive tissue damage.

We enrolled him in the Minnesota Cannabis program in January 2017. Within a week of beginning cannabis therapy Julian was able to go about an hour without harming himself. As the weeks went on and we reached a therapeutic dose Julian's behaviors began to slowly melt away. By early March he was smiling again. Within 6 weeks of beginning cannabis Julian was no longer injuring himself or others. He began to take an interest in his life again. He returned to school full time. We were able to remove his helmets and protective gear. By mid March we were getting smiles and hugs. Julian began to go outdoors again by mid-April. By May, Julian began to show interest in using augmentative communication for the first time in his life.

It is now late June. We have not seen 1 episode of self-injury since early March.

June 6, 2017

Advanced Microglial and Cannabinoid Signaling in Autism
Plant-Based Nutrition Certified,
Cornell University

Re: Minnesota lawmakers - Expert support for autism as qualifying condition

Autism & Cannabis – Physician Support

This brief summary provides "additional supportive evidence" for Minnesota lawmakers to justify autism as qualifying condition for their medical marijuana program. Please refer to the first document entitled "The Endocannabinoid System as it Relates to Autism" to appreciate further scientific evidence.

Recommendation

Dear Colleagues, I am the father of a 12 year old son who has autism. I have found great interest in pursuing possible etiologies in the development of the condition and explore safe alternatives to conventional pharmaceutical intervention. I am a speaker at multiple national conferences, specifically focused on autism and cannabis. As you know, several states have autism as qualifying diagnosis and more and more are to follow in the coming years. I have provided testimony in several other states about this same issue at hand including Texas, Maryland, Pennsylvania, Georgia and South Carolina.

Since I am sure you are aware, cannabis is non-lethal to humans. There are no reported deaths in recorded history that are attributed to cannabis as the cause of death.

The only question that really should be asked is if chronic cannabis exposure to the developing brain can be harmful. I share the same passion to protect our children. I am a father of four and am caught in the health-nut movement, where everything I offer them is safe to consume, free of refined sugars, genetically modified foods and more of such nature. Recommending cannabis to this subpopulation comes with a great deal of research.

I am giving my full support for giving parents the choice to choose cannabis as treatment modality in autism spectrum disorders. The reasons are as follows:

- I have seen countless parents' success stories with cannabis treatment, especially self-injurious, severe autism
- I have seen parents with their treated children for several years without adverse effects,
- I have researched this thoroughly. Cannabis is not only safe, but therapeutic (evidence below),
- This is not meant to change novel treatment recommendations for autism in any way. This is meant simply to be a legal choice for those parents that desire to choose cannabis for their child. It offers them legal protection from prosecution,
- Many "do it" without having "cannabis-cards" anyways. This causes additional stress for already struggling families.

I have personally consulted with Professor Grinspoon, who is a renowned Harvard Psychiatrist for 40 years and was reassured that cannabis is the not toxic in the developing brain. I have also consulted Professor Mechoulam, who discovered the THC molecule. In fact, he is still active as professor in Israel and is involved in the first human trial with cannabis and autism [out of all diseases].

If you see the powerful transformation yourself, when you listen to powerful parent testimony, it is our duty to protect these parents from state or federal interference. We must protect these very brave, yet vulnerable parents.

Thank you for your time to hear these parents and physicians and thank you for your time researching this subject as thoroughly as I have.

Vignettes

7 year old male: ASD, Tourette's, aggression, rage episodes and anxiety. After starting medical cannabis there was a 60% reduction in tics and aggression, an increase in his tolerance of others and more rapid de-escalation and recovery from rages – by parent report.

8 year old male with ASD, Tourette's, aggression and anxiety. Once starting medical cannabis, and after a few adjustments in the combination of THC and CBD, there was a 70% reduction in tic behaviors, 40+% reduction in aggression, 50% reduction in anxiety, and a 40% improvement in his sleep, per his parents.

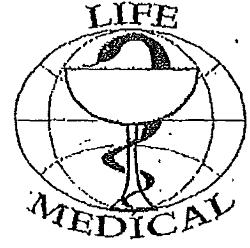
8 year old male with ASD, Tourettes, and anxiety: after starting cannabis there is a 50% reduction in raging episodes with a 40% increase in flexibility to transitions, and a 70% reduction in tics as reported by parents.

13 year old female with ASD, Tourette's self-injury, aggression, and anxiety: Picking and self-injury behaviors nearly resolved, vocal tics 90% improved, aggression symptoms were "less frequent" but, more importantly, "recovered much faster" from aggressive episodes, as reported by caregivers.

10 year old male with Tourette's and ASD on 8 medications to manage behaviors: initially an 80% reduction in tics, 30% reduction in anxiety, and 20% increase in willingness to try new things, increased flexibility. Parents report that he is continuing to show significant improvement in his anxiety and transitions and his tics have all but disappeared.

17 year old male with ASD, Tourette's, anxiety: Mom reports his "life has completely turned around". His tics were so severe he could not attend school, sit long enough to do homework or participate in family activity. I hardly recognized him at his last visit because he was transformed into a sociable, smiling, happy young man!

6 year old with Tourette's and ASD: prior to starting cannabis, this child actually broke the ceiling light in the office with a stuffed animal, tried to walk up the inside of the door, could not sit for more than a second and his vocal and movement tics were out of control. The family had tried a number of medications and had failed a recent trial of clonidine. After three months with medical cannabis he is able to sit through the visit, he is able to accomplish some study activities, is far less aggressive and is sleeping better than he had been for his whole life per MOM.



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07-20-2017

Minnesota Department of Health Office of Medical Cannabis
P.O. Box 64882
St. Paul, MN 55164

To the Minnesota Department of Health,

My name is Dr. Jacob Mirman, I graduated from the University of Minnesota Medical School and completed my residency in primary care internal medicine at Illinois Masonic Medical Center in Chicago. I specialize in integrative medicine and I am the Medical Director of Life Medical, an integrative medicine clinic in St. Louis Park.

I write to you today in support of the petitions to add nausea, autism, dementia, Alzheimer's disease, liver disease, and chronic pain to Minnesota medical cannabis program. As a physician treating patients for all these conditions, I believe my patients who suffer from these conditions would benefit from being added to the state's program.

I am a primary care internist. I am a not a politician, a law enforcement officer or a cannabis policy expert. Yet, as an internist with 25 years of experience working with patients, I hope you will consider my views on whether to expand Minnesota's medical cannabis program.

I have been certifying patients for medical cannabis for over a year now, and have seen a tremendous benefit to patients when they return to me for follow-ups. Notably, in addition to the medical condition that qualifies them for the program, many patients who I have certified suffer from some other ailment — including several listed above — and have seen their conditions improved with medical cannabis use.

Patients come to me because they need help. I agree to see them and do my best to help them. The buck stops with me. If I send a patient to a specialist and he or she is unable to help, the patient comes back to me and their medical care is again my responsibility.. When standard approaches do not help the patient, my responsibility as their physician does not end.

For the last few months, around 20% of my practice has involved treating patients benefiting from medical cannabis. I certify on average two-three new patients per day. Notably, many patients are finding relief for not just the condition they have been certified for, but also secondary conditions. Further, my patients are happier, suffer from less anxiety (many have

My name is [redacted] and I would like to share the story of my 21 year old son as a testimonial to the powers of medical cannabis, which I have found to be nothing short of miraculous. [redacted] has severe autism and a history of severe self-injury and aggression towards others. We are originally from Wisconsin, where we lived until 2012 when we moved to Missouri. During the 2.5 years we were in that state, my son's behaviors became extremely violent. He was kicked out of school and out of an adult day program for individuals with developmental disabilities. He literally ripped half of his own bottom lip completely off and to this day has numerous scars on his hands and legs from other self-injury. He was abusive and dangerous to our entire family. We attempted to have him hospitalized in an inpatient psychiatric facility numerous times; around 30 attempts to get help for him over those 2.5 years but they only took him 4 times, for 4-5 days each stay. During those hospitalizations, they just kept adding more and more psychotropic medications until he was at a point where he slept up to 18 hours/day and when he wasn't sleeping, he was violent and self-injurious - increasingly so. He was taking up to 18 pills/day towards the end of our residency in that state.

My husband was given the opportunity to move again, and we chose California. I had just heard of cannabis potentially helping people on the autism spectrum. This was our very last hope to keep him home and keep him and everyone else within our home safe. I had no idea if it would work. I had always believed cannabis was nothing more than a bad street drug. I believed it made people lazy and that there was absolutely no value to it at all. After seeing a video of a young child taking medicinal cannabis which almost immediately ended his violent behaviors, I began to reconsider all I knew about it. By this point, we had nothing left to lose. We were already expecting to have to institutionalize my son in California if the cannabis didn't work and this was our absolutely final thing to try in order to keep him home, since none of the other medications we tried in the past had helped him.

We started the cannabis within a couple of months of arriving in our new state. The results were almost immediate. I could see a change in his demeanor. He looked so calm, made eye contact, and just seemed to be more "present" in our world. Three days after beginning cannabis, we went to a National Park and he smiled and posed for the camera on his own. Before this, it was very rare to get him to smile for a photo. Now he does it all the time. Everything preconceived notion I had about cannabis in the past was incredibly wrong. It has helped and began to heal my son more than anything else, ever.

We slowly began weaning him from those 18 pills he was taking. It took 7 months to remove them all, but it happened! It has now been 19 months since he stopped taking pharmaceuticals. He no longer sleeps 18 hours/day. Instead of being violent every single day, he might have a minor episode once every 3-4 months and it can generally be stopped in under 5 minutes. Before cannabis, it might have lasted all day long or we had to give him extra doses to make him sleepy so we wouldn't get beaten by him. It has changed his life and our entire family's lives drastically. He is happily living at home with us and we have no plans to find another home for him anymore. He also spends part of his days at a new day program with his peers and he seems to enjoy it. We no longer fear him or his future.

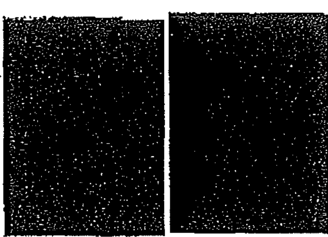
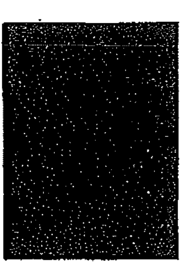
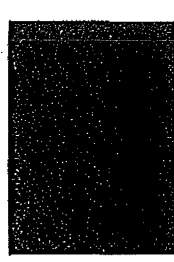
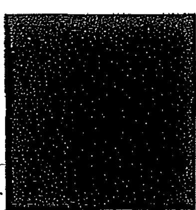
I am asking the State of Minnesota to add autism as a qualifying condition in your state's medical cannabis program. No child or adult should suffer needlessly. No parent should be prevented from trying everything they absolutely can to help their child. Zip codes and legalities should not be a reason a parent is unable to at least try every available option, especially one that is far less harmful than many of the pharmaceuticals they are oftentimes overprescribed. Please help this vulnerable population.

My son was diagnosed with Autism at age 3..He didn't speak or respond to his name and was constantly flapping his arms. He would shriek uncontrollably and bang his head forcefully on the floor, walls, and doors. He was unconsolable. He was constantly moving and showed no interest in what others were doing or saying. He had unusual obsessions (the washer, the microwave, the ceiling, holes.) He has cycled through countless repetitive behaviors. Stomping, spitting, clearing his throat, jumping,pushing his younger brothers, pinching, spinning, and most recently echoing the same word or phrase. His aggression and destructive behaviors only got more intense with age. Punching himself in the face, biting his legs and arms, throwing his whole body on the floor, scratching until he bleeds, punching holes in walls, throwing objects. He has multiple scars and has given me 3 black eyes

He had no interest in his brothers and was unable to make eye contact, use gestures, or communicate in any way. He has been nonverbal for most of his life. Lack of communication led to much of the aggressive behaviors, but at times it was random and seemed like he was in pain..

He had Speech Therapy, but was unable to focus or follow simple directions. He did Occupation Therapy but was discharged due to "unknown underlying medical conditions." Kindergarten was a nightmare. He was left out of special events and spent most of his day in a room with only two other students. He was not allowed to join the mainstream classroom or participate in Kindergarten graduation because they did not want to upset him by changing his routine He started ABA (Applied Behavior Analysis) Therapy in August of 2015. The behaviors continued and we felt there was no choice but to try medication, in retrospect this was a mistake. Within a year my 7 year old son was on Buspirone,Tenex, Prozac, Klonopin, Hydroxyzine and Abilify. These medications had zero effect, put him to sleep, or put him into a violent rage. The risks outweighed the benefits.Risperdal was prescribed as a last resort, but thankfully he was re-evaluated and given a diagnosis of Tourette's Syndrome.

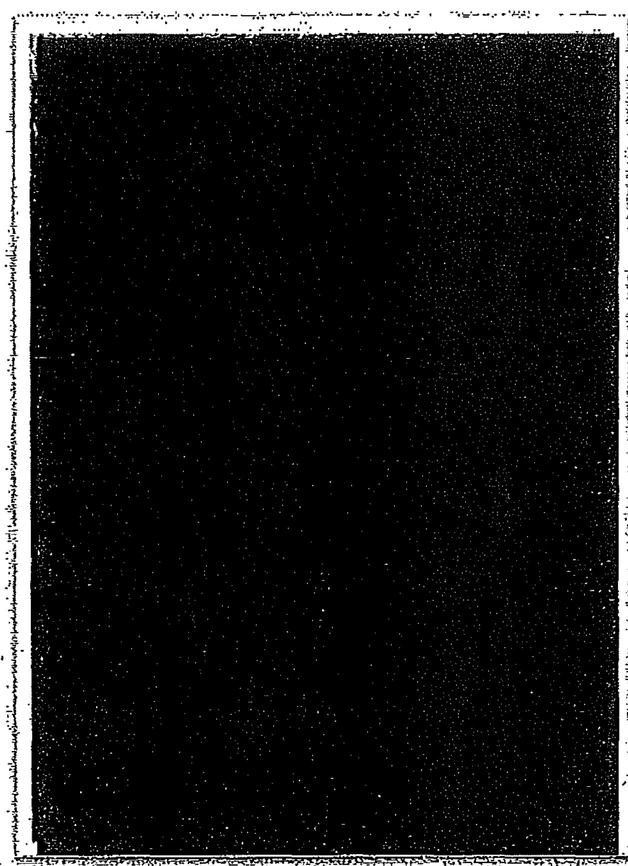
was certified through the Medical Cannabis Program last November. While it has only been a short period of time, his quality of life has dramatically improved.He is able to communicate by speaking simple words and using his AAC (augmentative and alternative communication) device. He is generally in a very good mood and smiling. Eye contact has improved and he plays with his brothers.He can wave at us, label objects, and says mom and dad. He is of all other medications and is much easier to redirect and calm down. Of course we still have off times, but they are rare. I don't have to worry he will have an allergic reaction or hurt himself or others. Medical cannabis has given my family hope.

To whom it concerns,

My name is [redacted] I am the very proud mom of [redacted]

[redacted] is 11 yo and has severe autism, as well as Lowe Syndrome (brain/eye and kidney disease) and Tourettes. He has been certified to use Medical Marijuana in the State of MN for his Tourettes condition since September of 2016, nearly one year.



In his one year since beginning Medical Marijuana- [redacted] has potty trained daytime hours, he has learned to dress himself with 1:1 step direction, he is able to transition 80% better, his anxiety levels have been decreased significantly, he has returned to fulltime school and is doing well, he is learning new tasks all the time, he is playing appropriately with toys, he is interested in other children and joining in on their play, he is willing to eat new foods and eats them regularly (cucumbers, raw apples, carrots, almonds, walnuts) he is able to receive a haircut with electric clippers without any behavior. His kidney function has increased, he was functioning at 66%, last check he was functioning at 80%- recheck due in August.

[redacted] has been weaned off Abilify- please see side effects of this med. He has also weaned ½ off Risperidone, we had to stop weaning as the withdrawal was horrific- he remains at 0.5mg day, we are working up the courage to try again...the withdrawal was heartbreaking for all.

We are very fortunate to have a Tourettes diagnosis as it gives us legal access to Medical Marijuana, I come forward to petition with others again this year as I believe in this medicine, I believe in it- I'm living the difference and feel every person with Autism should have the same freedoms my son does.

Medical Marijuana has been life changing for my son and our entire family.

My son ██████ - now 10 years old - was diagnosed with Autism at age 3. He also has ADHD, and Intellectual Disability. I knew he had this disease at 15 months old as he stopped meeting his milestones. He started screaming sometimes continuously on and off for days intermittently as if in pain, and beating on the right side of his head under the ear. Although ██████ is verbal, his cognition is delayed to the level of a 3-4 year old. ██████ can obey one step commands but no more.

Self-injurious behavior and aggression are the biggest concerns although there are many. ██████ has adverse reactions to medications, limiting him to certain ones. One medication required me to have him transported by ambulance to the hospital for a very long admission. ██████ has signs and symptoms of sub-clinical seizures, although numerous EMG's have detected nothing. I have recorded these episodes and others have admitted these episodes are possibly absent seizures.

██████ has had very thorough ABA therapy and treatment along with placement at a behavior facility in Wisconsin for one year. These approaches have not been effective. Redirection has only been successful 22% of the time. ABA has never been successful and has resulted in discharge of the ABA facility. ██████ has head pain in the right back side the head in which he beats under the ear at full force – his hair has ceased to regrow in the area due to consistency of striking and digging in that area.

██████ is afraid of children thinking they will hurt him which makes ██████ aggressive. We cannot go to waiting areas of clinics. We must be immediately directed to a quiet room or he will attack others due to noises. ██████ needs to be reduced in his medications. Risperdone causes obesity and trying other medications causes adverse reactions. Depakote was used and continues to be used for aggression although recently ██████ had a high toxicity and was admitted to the hospital. His head pain continues and there is no medication to calm and treat. Nothing works and Benzodiazepines cause adverse reactions.

I discharged ██████ recently due to neglect at a Crisis home as another child abused him. I believe this could have been avoided if put on the program and ██████s cognition and verbalisation would have cleared a lot more up. I believe I have a right to this natural medication after multiple have failed and we have nowhere to turn.

My son also vocally ticks in the morning and randomly throughout the day. He has resorted to biting his forearms as his way of crying out in pain. Do I think he is in pain? Your doggone right I do. When a child tells you that, you don't consider them a liar.

These strong medications need to be reduced and I believe Medical Cannabis administration is the key to keep ██████ healthy. Please make Autism a qualifying condition to help my child - I feel I have tried everything and I don't want to lose my child. I believe after reading about the endocannabinoid system and the benefits of getting ██████ certified by the Minnesota Medical Cannabis Program that we could save ██████s life and save lots of time and money spent. The expense of multiple admits, inpatient facilities, safety of others and safety of a suffering child, far out way the benefits of the medication itself.

Thank you for understanding my concern.

██████

Please see photos on following page.

I wish to remain anonymous. My 17 year old son has been diagnosed with ASD, ADHD and Depression with Severe Anxiety. Over the years, his aggression (rage attacks) and anxiety have gotten worse. During a rage attack, he punches holes in the wall, smashes windows, bangs his head and breaks items by kicking or throwing stuff. Walking in our house resembles a battle zone. His siblings often lock their bedroom doors, barricaded inside, to avoid him and his behaviors. His anxiety has gotten so bad that he is unable to order food for himself at Mcdonalds or any sit down restaurant. He doesn't leave my side when we're in public as he's afraid of being abducted. He's tried Abilify and Risperdal for ASD, Adderall, Ritalin and Concerta for ADHD, Seraquil, Zoloft, Paxil and Hydroxizine for Anxiety. None seems to help. His current prescriptions are Adderal, Abilfy, and trazadone to help with sleep. My son hates taking these meds and often refuses as they make him feel "out of it", sick to his stomach with no appetite, and his body aches all the time, not to mention what these meds do to his sleep cycle. During his rage attacks he also bites himself, punches us (his parents), and cuts himself. He usually ends up restrained and the police are called to calm him down.

Recently, my son has been self-medicating with marijuana. We as parents disapproved strongly at first. However, since he started using, we've noticed a huge difference in his demeanor. He is calm, rational, happy and we no longer see any rage attacks. He's nice to his siblings and to us, his parents! I don't see him constantly worrying, he has an appetite and he is able to sleep without medications. Please consider adding ASD to the list of approved conditions for medical marijuana use. My son's happiness\life depends on it.

My name is . I'm the mother of a 14 year-old boy named . has severe Autism and a seizure disorder. began having seizures in June of 2011. We have tried many medications over the last 6 years, however seizures and motor tics continued to be an issue.

had always been a kind and affectionate boy in his younger years. When turned 13, the onset of puberty brought new challenges. In February of 2016 became extremely violent toward both family and school staff. He began raging daily and would physically attack us. It got to the point where we as his family needed to wear protective clothing to avoid being bitten, having our hair pulled, and being kicked and punched. His younger sister could not be in the same room and she had to spend all of her time at home locked in her room for her own protection.

In August 2016, began to turn the violence on to himself. He began punching himself in the head full force thousands of times per day. He would use his knee to injure his teeth. He would bang his head into walls. We were powerless to stop him. We were trying to protect him using helmets, arm immobilizers and at times we had to physically restrain him for hours at a time to keep him from harming himself. We believed our son was in terrible pain and was suffering from debilitating headaches. We saw this once vibrant boy lose his will to live. He seemed determined to end his life and came close several times. Between October 2016 and January 2017, was hospitalized 3 times. He suffered self-inflicted skull fractures and massive tissue damage. He had black eyes and giant hematomas on his skull regularly. The hospital staff offered psychiatric medications as well as gabapentin but nothing could stop the daily rages that lasted every moment that he was awake. I felt certain that if we could not get cannabis that he would find a way to end his life.

qualified for cannabis through the state program because of his seizure disorder. After being sent home from Children's Hospital in Minneapolis after another life-threatening episode of self-injury with no plan in place to heal our son we felt cannabis was our only hope. The excruciating pain our son was in was getting worse and we knew no pharmaceutical medication could help him. We had tried everything the doctors offered and had absolutely no success.

We enrolled him in the Minnesota Cannabis program in January 2017. Within a week of beginning cannabis therapy was able to go about an hour without harming himself. As the weeks went on and we reached a therapeutic dose, 's behaviors began to slowly melt away. By early March he was smiling again. Within 6 weeks of beginning cannabis was no longer injuring himself or others. He began to take an interest in his life again. He returned to school full time. We were able to remove his helmets and protective gear. By mid-March we were getting smiles and hugs. began to go outdoors again by mid-April. By May began to show interest in using augmentative communication for the first time in his life.

It is now late June. We have not seen 1 episode of self-injury since early March. has not struck me since February. is enrolled in a day camp for children with special needs where he spends 8 hours a day. He is exploring outside and making friends. He is happy and smiling. and his sister have a relationship once again. spends hours in our backyard enjoying bouncing on his trampoline, moving his body and taking in fresh air. He lives safely and happily in our home. He is free from pain. His seizures and motor tics are well managed to the point they are not interfering in his daily life.

Cannabis gave us our beautiful son back. is alive and well today because of this miracle medication.

On the following page are photos of my son before cannabis therapy and after.

I am a mother of a 10-year-old boy. We did not learn about his Autism Spectrum Disorder until he was 7 1/2 years old. Looking back now, we can see the signs were there in a subtle way starting from infancy. It was at age 6, when he was ready to move to a mainstream school, that his challenges became more apparent. The dominos kept being pushed, and my boy kept having a harder and harder time. He went from being a happy and clever and confident child, to frustrated, sad, anxious and self-doubting in a fairly short amount of time. When we were told that he has High Functioning Autism Spectrum Disorder, we, as parents, grieved. In our grief, we pushed and plugged forward. School was there for us and there has been constant support and communication as changes are happening frequently.

Our son's ASD manifests as high anxiety, and quick triggers. He becomes frustrated with anything that he perceives as a block to a goal or need. He has the emotional maturity of a 3-4-year-old. He has an emotional response and is overwhelmed to what I would compare to a person experiencing a PTSD reaction. He experiences sensory input more than a typical developing person does, and the overwhelming sensory overload leads him to deep frustration and a fear response. He yells and cries and gets in a looping thought pattern that keeps himself stuck in that trauma reaction. These episodes have become a serious block for social interaction and development since other children cannot understand what is happening for him or why he is yelling at them. His ability to understand his own emotions and express his needs and wants as well as lack of problem solving ability keeps other children from wanting to interact. It even triggers other children into pushing buttons to elicit an outburst because it seems "funny" to them. Now we have bullying happening with that. He also has ongoing stories happening in his mind, and he retreats into a world within his imagination. It has become increasingly difficult to get him out of the stories and the retreat world within his head. From all of this, we now have a highly anxious and depressed child. He is a highly intelligent child. With his smarts (high IQ), he actually is aware that he is different from others. He sees that he reacts and experiences things differently, and he knows that it is hard on others. With that, he also knows that he is not able to stop it. With this, he experienced not only sadness, but a deep loneliness. Talk of suicide began at age 9. As he came into the school from recess, a staff-member noticed that he was walking slowly and looking down rather than his typical demeanor. The staff-member asked him what was on his mind and he said that he wished that he had a rope so that he could hang himself. Further discussion of these feelings revealed that his first thoughts like this actually began internally at age 7.

He has been on Adderall XR (amphetamine salts), a stimulant for treating his inability to focus and attention. This has been helpful with focus, but he has had an increase of anxious behavior and panic attack/ PTSD-type trauma reactions. Although I brought this up and asked what we could do differently over numerous visits to his prescribing Nurse Practitioner, she never had any answer except for adding more pharmaceuticals. I am in the Health care industry, and I am not against medications when used appropriately. We added Intuniv (guanfacine extended release) for his impulse control, and that helped, but the anxiety and panic and

frustration tantrums kept getting worse. The clinician suggested a few times that an anti depressant and then after that, a mood stabilizer could be tried. This is where I drew a line. Anti depressants in youth can actually increase the risk of suicidal thoughts, and with an already suicidal boy, that is not an option for our individual child. The mood stabilizers also come with side effects that we refuse to risk. Other medications suggested have frightening side effects and if ever we wanted to take him off of them, risks with withdrawal symptoms are unacceptable.

I am a very scientific thinker, so I read and researched various articles, both academic and anecdotal. The idea of Medical Cannabis crossed my path. From my detailed searches, I found that children are medicated using medical cannabis and they are NOT getting high. I learned about Cannabidiol (CBD), which does not have the psychotropic effect on people. I did not like the idea of Tetrahydrocannabinol (THC), because I did not want to risk my kiddo getting "high" and also because, it is against the law. I found products that we could legally obtain with whole plant extractions of CBD, and purchased CW Advanced. I connected with a non-profit group in Colorado, and they directed me to the "start low and go slow" method. We gave our son his first very small dose of CBD oil on April 19th in the evening. We used the guidance of the non-profit group, and found a dose based on his weight. Within a just over two weeks of adding CBD to his treatment plan, we received an email that said,

> *" Hello All-*
> *I hope [child's name removed] is feeling better.*
> *I wanted to let you know that [he] had a really good week. He was focused, on task, flexible, and able to recover quicker from bumps in the road. It was a drastic improvement from the past couple of weeks, regarding his flexibility and focus."*

His father and I both were seeing improvements at home with his communication and seemingly easier time recovering from frustration. With a lot of research, I found a way to obtain cannabis strains that have THC and are found to be helpful for other parents that have a child similar to mine. As a parent desperate to treat my child, I crossed a legal line. I traveled to a "legal" state and purchased a few strains with guidance from other parents who are further along in their journey. As his parents, we agreed that we would try this in secret.

What we saw since adding a tiny amount of THC is beyond even what we had hoped for. Within a week of adding THC as medication, we watched our child face a challenge that lasted over two hours, and instead of having a full-out breakdown, he worked through it. He told himself after repeated "failure" things like "You can do this" and he just tried over and over. He also accepted corrections, which he typically never would without high defensiveness and anger. That was just a start. He was also having real back-and-forth conversations with us as well as peers and other adults. His eye contact greatly increased, and he even began asking other people their thoughts and about how they were doing. He never before would ask someone "How are you" even. His thoughts began to be outside of his inner focus and inner world. Something simple, but noticeable is that he never looked into a camera and he could not smile on command. It took someone else to point

out to me that he was not only looking at the camera, but he was smiling....as in a real and genuine smile! We continue to see him blossom socially. He has found an awareness of his emotions and identifying them to himself, and sharing them with people around him. He is open to listening to ideas to improve outcomes where defensiveness would have blocked him before. He is having fun again and interacting with other children much better. His awareness is reaching out of his own world that he had been trapped in prior to treatment involving Cannabis. We are parents who are successful in our careers and social lives. We have been law-abiding citizens up to the point of desperately seeking medication that has not been available in our state for our child. Please consider making Medicinal use of Cannabis available to our son so that we can legally treat his Autism Spectrum Disorder under medical guidance within our own state of Minnesota.

Thank you for considering adding Autism Spectrum Disorder a qualifying condition under Minnesota's Medical Cannabis program.

With Great Hope,
*A loving Mother

*For obvious reasons, I wish to remain anonymous.

July 24, 2017

Hello,

I am writing to share our family's experience with medical cannabis and express how important it is for Autism spectrum disorder to be added as a qualifying condition for the MN medical cannabis program.
Our journey with cannabis began in 2015, when we first heard about CBD oil. We began using it for our son [redacted]. [redacted] has both an ASD and a Tourettes diagnosis. We started with the CW brand and switched to the HH brand 3 mos later (we feel the HH brand is a high-quality and reliable product). This initial test with CBD oil proved extremely successful for [redacted]. [redacted] had been having extremely aggressive meltdowns reguarly. They occurred most often from going out into the community and having sensory overload. The meltdown would occur once he returned home. He would attack me and my husband (as well as therapists and school staff) when overwhelmed. We stopped going anywhere except routine places (basically school and therapy) to lessen these fits. However, they would happen randomly as well. The fits also terrified his little sister [redacted] (who also has ASD and Tourettes), causing much anxiety in her.

When we began CBD oil, the aggression during fits stopped. He no longer hit, kicked, or attacked us when upset. He still had meltdowns, but they were much shorter and the removal of the aggression was a huge improvement.

We also saw an increase in focus during ABA sessions, more eye contact, an increase in his wanting to and trying to communicate with us ([redacted] is semi-verbal, only able to make short requests or use learned phrases - he cannot hold a conversation or answer a question). When he started school again in the fall that year, staff were blown away by the changes in him. His FBA had to be rewritten after only one year due to the behavior improvements.

As a family, we were able to attend movies and go to Disney on Ice productions. [redacted] began ice-skating lessons and participated in Special Olympics basketball that winter. He was happier and visibly more comfortable. The CBD has helped his leaky gut issues as well, reducing inflammation and pain.

In 2016, [redacted] became registered with the MN Medical cannabis program under his Tourettes diagnosis. We tried a variety of different options with the guidance of the MN Med company. We did not see a lasting improvement in [redacted]'s tics however, after almost a year of trying the MN Med products. Currently, [redacted] is only taking the HH product, but we will keep trying to help him through the state cannabis program in future. It is very important to note how many of my son's ASD based symptoms - the aggressive meltdowns, lack of communication and eye contact, anxiety and sensory overload - all reduced due to CBD oil.

Our daughter [redacted] became registered with the MN Medical cannabis program in Aug 2016, with Tourettes being her qualifying condition. We saw initial improvement with tic reduction right upon starting the MN Med green product. This remained for about 4 mos until we purchased a new bottle of this product. For some reason, the new bottle did not have the same effects and stopped working. We switched companies and the Leafline product is working better, in combination with the HH product.

My daughter's ASD symptoms improved as well with both MN cannabis products. She became calmer, happier, and less anxious. Her speech improved and her spontaneous language increased. Her ability to answer questions also improved.

Being able to help my children by using the MN Cannabis program has made a huge difference in their lives and our family's life. There are many children out there with only an Autism diagnosis who would surely benefit from having the same access to this program. Medical cannabis has proven to help with so many of the symptoms and side effects that go with ASD - inflammation, speech/communication improvements, gut and digestive issues, sleep issues, behavior issues including aggression and self-injury, anxiety, depression, and other mental illnesses - just to name a few.

Why should these children and their families continue to suffer each day when there is an option that is safe and may help them? Please consider adding Autism as a qualifying condition for the MN medical cannabis program.
Thank you for reading our story.

Sincerely,

July 25, 2017

To Whom It May Concern,

My name is [redacted], my husband and I are sending this letter to share our family's personal experience with our daughter [redacted]. We are praying that the diagnosis of Autism Spectrum Disorder will be added to the list of Qualifying Conditions to the Medical Cannabis Program.

Our daughter's name is [redacted] she is 13 years old and is an exceptional artist, writer, illustrator, and has a heart of gold. She inspires us each day to be the best parents that we can be, to protect her, and nurture her in any every way possible. One of the challenges of parenting that we have is watching her struggle on a daily basis.

[redacted] was diagnosed with Autism Spectrum Disorder when she was 10 years old after many years of trying to figure out what was causing her to struggle severely in many areas of her life. [redacted] struggles with social communication; she has difficulty with peers and adults, and lacks skills in social settings. As she is in adolescence these deficiencies are more noticeable and upsetting to her. She also struggles with repetitive patterns of behavior and interests. Her focus on subjects and intensity are admirable, but they truly impede her happiness and success in areas of her life. She struggles with transitioning from one item to another and has difficulty engaging with others when she is hyper-focused on a subject or object. [redacted] also struggles with her behavior; she has rages daily when it comes to transitioning and carrying out her activities of daily living. She has anxiety, depression, and has also been diagnosed with Disruptive Mood Dysregulation Disorder (DMDD). [redacted] will self-injure as well as hurt others when she is unable to manage her emotions and is having sensory overload.

Due to her challenges she has been hospitalized multiple times. These hospitalizations have been to stabilize her as well as to attempt to manage her medications. We have had so many challenges with pharmaceutical medications that have been harmful immediately and over time. [redacted] currently is pre-diabetic, has high tri-glycerides, as well as high cholesterol. The medication that causes her to have these side effects also causes her to have insatiable hunger and has affected her self-esteem as she does not look like her peers. She is on an additional medication to help curb some of these side effects as well. We have tried many types of medications and have had major side effects with each one. A combination of medications prescribed caused her to be hospitalized due to aggression and extreme confusion where she struggled to speak. Another medication caused [redacted] to start lactating at age 11. We have recently been referred to a new Psychiatrist specializing in Autism Spectrum Disorder to hopefully come up with a plan that will keep her stable, functioning, safe, and not cause more serious health concerns due to side effects.

As [redacted]'s parents we struggle to make careful and informed choices about her medications. We have the best and most knowledgeable providers for her and they are running out of options to help [redacted]. As parents we want to protect her and ensure that as she is moving through life, she is safe, and able to realize her goals and aspirations. At the rate we are going many of these will not happen for [redacted] and as parents it breaks our hearts.

We have heard of many success stories from other families who use Medical Cannabis for their children who have qualifying conditions. The changes in these families' lives have been extraordinary. The ability to move away from pharmaceutical medications that can cause damaging side effects has been a blessing for so many people. As parents we would move heaven and earth for our child and truly need to have other options to treating her. We are asking to please allow Autism Spectrum Disorder to be added to the list of Qualifying Conditions in the Medical Cannabis program. The addition would allow families options for treating their children's illnesses and allow stability and safety without the fear of damage.

Thank You

[redacted]

Marijuana madness

Nick Buglione

is convinced marijuana saved her child's life.

Just six months ago her son, a 10-year-old with severe autism, weighed just 46 pounds. He stopped eating after the medications he had been taking to control his behavior took away his appetite, according to the Orange County, Calif., mom.

"You could see the bones in his chest and in his arms and legs," says. "He had stopped walking and he would bruise very easily."

But it was medical marijuana, an unorthodox treatment for autism that's been the center of debate recently, which got her child eating again and changed his life for the better, she says. It was not a decision she made lightly. "I decided to try medical marijuana truly after I exhausted every other treatment," says.

About five years ago began exhibiting behaviors typical of children with severe autism—he would hit himself, bang on walls, and throw anything he could get his hands on. "He was very unpredictable," she says, so much so that she shied away from inviting company over or taking to someone else's house. "I could no longer socialize with friends or family due to his behavior."

tried behavior modification, a gluten-free, casein-free diet, and over 13 different medications with limited success, she says. While some of the medicines managed to reduce outbursts, the results were fleeting, according to the mother. "The effects of the medication were temporary. It seems like every three weeks we were either changing the doses or changing the medication, which is normal, but that took a toll on his body," she says.

All of the medicines—including Ritalin, Focalin and Risperdal—had serious physical side effects on Thee were facial ticks, seizures and liver damage, but worst of all, a lack of appetite that left emaciated and weak, his mother says.

As grim as the situation was, it was a light-hearted moment with friends that clued in on the possible benefits of marijuana. "I was sitting around with friends and it started as a joke," she says. "We were talking about how marijuana users eat, they sit down, they're very calm, and they're pleasant to be around."

Later that night she typed "autism and medical marijuana" into an internet search engine and the name Dr. Bernard Rimland popped up. Rimland is a former director of the Autism Research Institute who wrote about using medical marijuana to treat autism.

"I'm not pro-drug, but I am very much pro-safe and effective treatment, especially in cases when an autistic individual's behaviors are devastating and do not respond to other interventions," Rimland once wrote. "Early evidence suggests that medical marijuana may be an effective treatment for autism, as well as being safer than the drugs that doctors routinely prescribe."

According to the Autism Research Institute, some of the symptoms marijuana has improved in children with autism include anxiety, aggression, panic disorder, tantrums and self-injurious behavior. Though Rimland died in 2006, his ideas continue to draw interest from parents with children on the spectrum.

California is one of 14 states that now allow the use of medical marijuana with a doctor's prescription. After consulting with pediatrician, began administering it to her child by baking it into brownies.

The mother says she noticed an improvement immediately. " was mellow," she says. "He wanted to sit in his room and play with his toys. Autistic kids don't want to play with toys. We noticed that he wasn't on edge as much."

For the past seven months has been taking one marijuana brownie—about the size of a 50-cent piece—every two to three days. "The other meds I was giving to he would take three times a day and they were not having the same effect as the medical marijuana," says.

The improvements continue to be evident, she says, as is now smiling and even attempting to talk—things he never did before. Having appeared on Good Morning America and other media outlets, is spreading the word about medical marijuana and autism. She has even started her own website, uf4a.org. "There are definitely other parents who are using it but I'm just the only parent that's gone public," she says.

And though she lives in a conservative county in California, the response to her grassroots campaign has been overwhelmingly positive, she says. "The positive feedback has far outweighed the negative feedback," she says. "After I was on Good Morning America, I received over 700 e-mails from parents asking all kinds of questions. I heard from a mother in Texas who had a child with autism die of malnutrition and she said she would have moved to California if she'd known about medical marijuana."

The mother is hoping her crusade will result in the California state legislature including autism as one of the treatable conditions under its medical marijuana law, which passed in 1996. AIDS, cancer, glaucoma, and arthritis are among the illnesses currently included. Although autism is not explicitly mentioned in the bill, doctors can prescribe marijuana for any other illness that it might provide relief.

"The medical community must start acknowledging the benefits of cannabis for our children with these symptoms. Finding a medical marijuana doctor to see a child is difficult – they fear the risk of losing their license," Hester-Perez says. "I called several doctors before I found a doctor for that I thought was morally in line with why we were turning to cannabis. For those who have exhausted all other treatments medical marijuana provides one more option that does not lead to death, liver damage and seizures."

isn't the only parent who has admitted to giving her child medical marijuana. an author and professor at Brown University, has a 9-year-old child with autism who is taking marijuana to treat his behavior. Though the mother declined an interview with Spectrum, she has blogged about the experience online.

In the last year the teachers at her child's school began inquiring about his behavior, even having to wear protective pads because his biting had become so severe, Lee writes. She didn't like the idea of putting her child on Risperdal, as its long term effects have never been studied in children, and became intrigued when a homeopath suggested medicinal marijuana.

"But I was resistant. My late father was an anesthesiologist, and compared with the precise drugs he worked with, I know he would think marijuana to be ridiculously imprecise and unscientific," she writes. "At his school, I was already the weirdo mom who packed lunches with organic kale and kimchi and wouldn't let him eat any 'fun' foods with artificial dyes. Now, I'd be the mom who shunned the standard operating procedure and gave her kid pot instead."

Lee's doctor put her child on the prescription drug Marinol, a synthetic form of cannabis, and her son showed a marked improvement in behavior, she writes. After he developed a tolerance to the synthetic drug, however, his aggressive behavior returned.

Since her state, Rhode Island, allows medicinal marijuana, filed the paperwork and her doctor consented, making her son the youngest person in the state to be prescribed pot. She says she's seen a steady improvement in his behavior.

, a mother of a 15-year-old with autism, decided in February to start her son on medical marijuana to control his anxiety and rage.

The Carpinteria, Calif., mom says her son behavior spiraled out of control when he reached puberty. "He had really withdrawn into himself and at that time he was almost non-verbal, even though he had been very verbal," she says.

put her child on traditional medication to reduce his outbursts, but like other parents, she was concerned about the long-term effects they might have. Since starting her son on medical marijuana Hosseini has noticed positive changes.

calms down within five minutes of receiving it," said. "He is more responsive and verbal, asking more thoughtful questions. He sleeps through the night and doesn't wake up. He has a good appetite. He is less resistant and more manageable and cooperative."

On the downside, the mother says the child is sleepier in the day and requires a nap. She's also noticed he's become more self-centered. "At a Mexican restaurant (recently), he yelled to the waitress twice to bring him chips," she says. "I mean yelled. Everyone was looking at us."

says she plans to continue giving medical marijuana, while closely monitoring his progress.

Though Kansas does not allow the use of medical marijuana, , a mother from Topeka, swears her son's recreational use of the drug helped him focus and develop empathy and social skills.

, now 20, was diagnosed with pervasive developmental disorder not otherwise specified when he was 13. He had significant cognitive delays and limited social skills, his mother says. "He was very impulsive and had no understanding of consequences," says. "He never seemed to understand emotions or facial expression. He would answer questions but couldn't just sit down and share ideas of his own or carry on detailed conversations. At 16, his reading level was about third grade and his writing ability was about first or second grade."

After entering high school, Louis fell in with the wrong crowd, his mother says, and began smoking marijuana. Though protested his use at first, she noticed a marked improvement in his behavior while on the drug.

"He was sitting in my living room and he had been smoking and he was watching a documentary on the History Channel on UFOs," she says. "I watched it with him. After the show was over I sat down with him and we talked about it. It was the first real conversation I ever had with my son. Tears came down my (face). I cried. I had never had a conversation like that with him in my life."

no longer takes the medication he has been on since his childhood to control his behavior. Instead he smokes marijuana once a day. "He has since explained that it slows his mind down without all the side effects of the medicine he was prescribed that never did anything but sedate him," Spurge says. "He can now sit still through a movie and understand the story without having to watch it several times. His vocabulary has grown. He still has some tics but not to the degree he had when he was younger. He can handle being touched and will even offer hugs to people he cares for."

Some 150,000 patients have received medical marijuana through Medicann, an Oakland clinic, since Dr. Jean Talleyrand founded it in 2004, including four with autism. "All four patients have had very good results," Talleyrand says. "Because I only have four patients, I'm not quite sure what combination of ingredients are affecting the children."

Courtesy Spectrum Publications

Source URL: http://www.autismsupportnetwork.com/news/autism-treatment-marijuana-madness-8763721

#4 Reference Materials in Support of Petition

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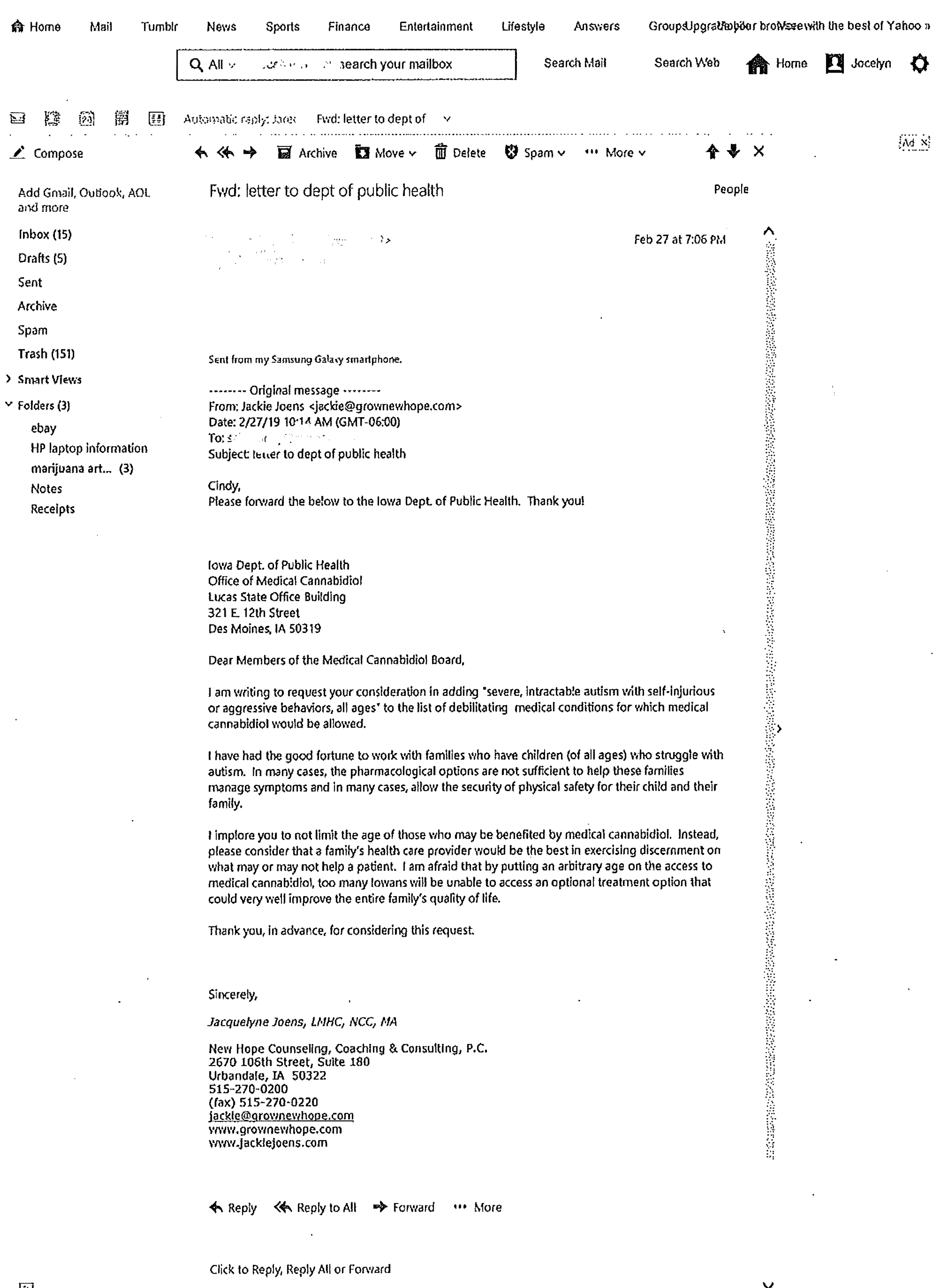
Anecdotal stories



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People

Fwd: letter to dept of public health

Feb 27 at 7:06 PM

Sent from my Samsung Galaxy smartphone.

-------- Original message --------
From: Jackie Joens <jackie@grownewhope.com>
Date: 2/27/19 10:14 AM (GMT-06:00)
To:
Subject: letter to dept of public health

Cindy,
Please forward the below to the Iowa Dept. of Public Health. Thank you!

Iowa Dept. of Public Health
Office of Medical Cannabidiol
Lucas State Office Building
321 E. 12th Street
Des Moines, IA 50319

Dear Members of the Medical Cannabidiol Board,

I am writing to request your consideration in adding "severe, intractable autism with self-injurious or aggressive behaviors, all ages" to the list of debilitating medical conditions for which medical cannabidiol would be allowed.

I have had the good fortune to work with families who have children (of all ages) who struggle with autism. In many cases, the pharmacological options are not sufficient to help these families manage symptoms and in many cases, allow the security of physical safety for their child and their family.

I implore you to not limit the age of those who may be benefited by medical cannabidiol. Instead, please consider that a family's health care provider would be the best in exercising discernment on what may or may not help a patient. I am afraid that by putting an arbitrary age on the access to medical cannabidiol, too many Iowans will be unable to access an optional treatment option that could very well improve the entire family's quality of life.

Thank you, in advance, for considering this request.

Sincerely,

Jacquelyne Joens, LMHC, NCC, MA

New Hope Counseling, Coaching & Consulting, P.C.
2670 106th Street, Suite 180
Urbandale, IA 50322
515-270-0200
(fax) 515-270-0220
jackie@grownewhope.com
www.grownewhope.com
www.jackiejoens.com

Reply Reply to All Forward More

Click to Reply, Reply All or Forward

Hello,

My name is Sara Ahrendsen and my nephew suffers from severe autism which also includes self-harm and aggressive behaviors. I feel it is very important that autism be included on the list for medical cannabidiol in the state of Iowa. For so many children and adults who suffer from severe autism they can't communicate which then leads to frustration which then leads to self-harm. For most of us we can't even imagine what that feels like as a parent. I know I can't.

Severe autism is not a curable disease and there are very few treatment options for these children and adults that actually help them get through the day without anger or self- harm. Many are forced to be away from their loved ones and options for treatment are not always beneficial when cases are severe.

It has proven to help calm a patient who has Parkinson's disease and epilepsy as well. We all have seen what it can do for these patients who suffer on a daily basis from these debilitating diseases. Autism is no different and for who suffers from severe autism, it would be nice to see him able to enjoy a day without being upset or hurting himself. His family would love to see have a calm afternoon while they visit him and maybe a few hours of rest.

We know this is not a cure for autism, but children and adults who suffer from autism deserve to benefit from medical marijuana as do so many other diseases. Please consider this as an option for children and adults with autism.

Thank you for your time and your consideration,

Sara Ahrendsen

Subject: Letter 2

From:

To:

Date: Monday, February 25, 2019 1:12 PM

February 25, 2019

Dear Members of the Medical Cannabidiol Board.

On November 27, 2018, the Iowa Medical Cannabidiol Board issued an order that modified and approved a petition to add Autism Spectrum Disorder (ASD) as a debilitating medical condition for which the use of cannabidiol would be medically beneficial. Specifically, the Cannabidiol Board modified and recommended the addition of severe, intractable pediatric autism with self-injurious or aggressive behavior.
Our nephew a 28-year-old young man has severe autism with self-injurious and aggressive behaviors. My Husband and I would like the board to consider adding "all ages"with severe intractable autism the list of medical conditions that can receive medical cannabidiol to the petition.

Sincerely,
Cindy and Tim Andreassen

Sent from my Samsung Galaxy smartphone.

March 1, 2019

Office of Medical Cannabidiol
Lucas State office Building
321 E. 12th St.
Des Moines, Iowa 50319

Dear Members of the Board,

I am writing regarding your recommendation that severe, intractable *pediatric* autism with self-injurious or aggressive behavior be added to the conditions for which medical cannabidiol can be used.

My adult nephew has severe autism with self-injurious and aggressive behaviors. I have been very involved in his care for his entire life. He is 28 now and has resided at the Woodward Resource Center since just before his 21st birthday. His placement there was not an easy decision for his parents to make. When he reached puberty his behavior changed. He started hitting people and himself causing injuries to both. He loved music and he suddenly started becoming obsessed with the computer and CD players which were things that once brought him joy, but now agitated him resulting in him losing the ability to listen to music and play on the computer. Since he's been at the Resource Center he's remained self-injurious and aggressive. He's put many holes in his wall and broke several recliners and TVs. My sister visits him weekly and I try to accompany her as much as possible. He often has bruises, cuts and abrasions of his hands, face and ears from charging into things or hitting himself. He once hit himself with an object hard enough to open up his scalp which took several months to heal completely due to recurrent trauma.

I love my nephew. I see Cannabidiol as his best chance at a better quality of life. Nothing will make him "normal", but Cannabidiol might make him more at peace with himself.

Please amend the rules to include severe, intractable adult as well as pediatric autism with self-injurious or aggressive behavior.

Sincerely,

Kathryn Sbiral
132 Hanna Blvd.
Waterloo, Iowa. 50701