



Published in final edited form as:

J Am Acad Child Adolesc Psychiatry. 2015 December ; 54(12): 969–971. doi:10.1016/j.jaac.2015.08.017.

Psychiatric Hospitalization of Children with Autism or Intellectual Disability: Consensus Statements on Best Practices

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Psychiatric hospitalization of children with Autism Spectrum Disorder (ASD) and/or Intellectual Disability (ID), is both common and challenging. Children with ASD are six times more likely to be psychiatrically hospitalized than children without ASD.¹ Due to the limited number of specialized psychiatric units for children and adolescents with ASD or ID in the United States, most admissions are to general child and adolescent psychiatric units. Staff may have limited experience with this population, and the treatment approach and therapeutic milieu may not be well adapted to children with ASD or ID. General units typically use verbal interventions (e.g., individual, family and group therapies), programming with high social demands, and general reinforcements (e.g., level systems). These interventions can be less effective in children with ASD or ID, who have impairments in social communication and cognitive abilities and may have rigid routines and preferences. Specialized units have shown improvement in the behavioral functioning of children with ASD or ID two months after discharge², as well as decreased readmissions,³ in two uncontrolled studies with an average length of stay of 26–42 days.

To identify best practices for psychiatric inpatient care of children with ASD or ID a panel of expert clinicians (child and adolescent psychiatrists, psychologists and pediatricians) from six United States specialized units convened. Due to the limited amount of research in this

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area, evidence-based recommendations were not feasible, and the panel undertook a consensus process based on existing literature and expert opinion gathered from a survey, a semi-structured telephone interview with the participants and regular conference calls.

Although inpatient facilities can have significant resource constraints, the following consensus statements encompass trends in practices currently utilized by specialized units, and offer a vision of how to best serve this population. As such, the panel sought to strike a balance between identifying best practices and providing recommendations that may be attainable on general units.

Consensus Statements

Children with ASD or ID and serious emotional or behavioral challenges can be treated in general inpatient psychiatric units, with specific accommodations

Inpatient treatment can be utilized to assess and treat persistent unsafe behaviors (such as physical aggression or self-injury), co-occurring mental health disorders and identify gaps in services and family system challenges. Hospitalization is not indicated for the treatment of core symptoms of autism or intellectual disability. Inpatient treatment may be more successful when employing specific accommodations and strategies, as detailed below.

Obtain information specific to the child with ASD or ID and their support system in the initial admission assessment

The admission interview with the caregivers should seek information on the child's preferences (e.g., foods, objects, activities), means of communication, reinforcement items, sensory sensitivities, triggers and early warning signs of agitation, effective calming techniques, and specific dangerous behaviors (e.g., hitting, biting, hair pulling). Self-care needs should be identified, including the ability to swallow medicine, and resources and challenges in the caregiver system assessed. Summarize important information in a tip sheet for direct care staff. Evaluate for contributors to problems behaviors, such as recent changes in the home or school environment.

Screen for a medical etiology of the presenting problems

Medical problems are a common etiology of emotional and behavioral challenges in children with ASD or ID, particularly if the child is non-verbal. Assess for conditions that have increased prevalence in individuals with ASD or ID (e.g., seizures, constipation, and sleep disturbance), are associated with specific genetic syndromes, or are common to all children (e.g., injuries, dental problems, ear infections). Current medications, including over the counter or complementary and alternative substances, should be assessed for side effects, such as sedation or irritability, which can contribute to emotional or behavioral challenges.

Assess for co-occurring psychiatric disorders and use evidence-informed pharmacotherapy

Psychiatric disorders co-occur at an increased rate in children with ASD and ID, but are at risk for mis- or under-diagnosis if symptoms are presumed to be part of ASD or ID. Assess for psychiatric disorders through caregiver and patient interview and observation, with a

focus on detecting change from the child's baseline functioning. This assessment should account for the child's level of communication and cognitive impairment, behaviors typical for the child's adjusted developmental level, and features typical of ASD or ID. Interpret standard psychiatric diagnostic instruments designed for typically developing children with caution. Consider use of evidence-based pharmacotherapy when there is an identified co-occurring psychiatric disorder or specific target symptom. Clinical practice pathways are available for attention-deficit/hyperactivity disorder symptoms⁴ and irritability⁵ in ASD.

Assess and support communication and occupational therapy needs

Communication, sensory, motor and personal care challenges can cause or contribute to emotional and behavioral problems. Currently used communication (e.g., voice output device) or occupational supports (e.g., glasses, weighted blanket) should be identified at admission and requested to be brought to the hospital. Children with unmet communication needs can show improvement in problem behaviors through use of visual activity schedules and alternative communication systems (e.g., picture exchange communication system (PECS) or augmentative and alternative communication (AAC) devices).

Conduct a behavioral assessment and collect data on observable target behavior

Children with ASD or ID are typically hospitalized due to observable externalizing behaviors. Assessment of the function of the behavior, based on the principles of applied behavior analysis, can identify variables that maintain problem behaviors. Create an individualized positive behavioral support plan based on the hypothesized antecedents (triggers) and consequences (reinforcers) of the behavior. Collect objective data on observable target behaviors to evaluate response. Include caregivers in reviewing treatment response and train them in the behavioral plan to facilitate generalization post discharge.

Adapt the unit environment and programming to create therapeutic spaces and activities appropriate for children with ASD or ID

Children with ASD or ID can struggle to follow unit rules and schedules due to difficulty understanding expectations and verbal prompting. Expectations and programming should be developmentally appropriate and consistent, can be communicated through a picture or written schedule, and should alternate preferred and less preferred activities. Individualized behavioral reinforcement systems (e.g., point or token systems) should use reinforcers specific to the child's interests, such as a favorite video. Provide a quiet space for those with sensory sensitivities to use when needed and keep the visual environment uncluttered. Provide access to sensory-oriented activities and materials for motor activity breaks (e.g. wall push-ups, using a small trampoline, squeeze ball) when needed.

Provide structured educational services during hospitalization to facilitate the transition back to school

Many emotional and behavioral challenges occur in the context of school demands. Providing a similar setting on the unit allows for a more thorough evaluation and behavioral plan. Contact the outside school regarding the child's behaviors, individualized educational plan (IEP), and prior cognitive, achievement and functional behavioral assessments. The

outside school should be informed of successful strategies, which can facilitate the transition back to school.

Provide direct care staff with training specific to working with children with ASD or ID

Train staff in the learning style, needs and range of abilities of children with ASD or ID. Staff should be knowledgeable in the use of behavioral strategies, visual structure, communication supports, positive reinforcement, and de-escalation strategies. A specialized background is not required. Training can be done in-house or through training programs developed for care of the population (e.g. NADD Competency-Based Direct-Support Professional Certification Program). It may be most sustainable to train a sub-set of staff motivated to work with this population.

A longer inpatient length of stay may be beneficial for changing patterns of externalizing behavior and facilitating generalization and multidisciplinary work

In order to assess and treat co-occurring medical and psychiatric conditions, identify resources and challenges in the care system, monitor response to treatment, change patterns of unsafe externalizing behaviors through behavioral treatment, and train families and providers in successful strategies, a longer length of stay may be necessary. Insurance utilization reviews that assess progress and risks, and affect length of stay, can be informed by the presentation of objective data on observable target behaviors.

Interpret standard medical necessity criteria for inpatient psychiatric care in the context of the developmental disorder

The medical necessity criteria health insurance companies and state agencies typically use to authorize inpatient care are homicidality, suicidality, or failure to care for self. The risk of denial of care increases if these criteria are inappropriately applied to this population, where the intent of physical aggression or self-injury sometimes cannot be determined due to communication challenges and many cannot care for themselves at baseline. Interpreting or rewriting the medical necessity criteria in the context of the developmental disorder is a more just and clinically sound practice. For those with ASD or ID, recurrent physical aggression toward self or others, or a decrease from baseline in the ability to care for self, are more appropriate criteria. Insurance companies may also insist that another psychiatric disorder be present, in addition to ASD, in order to approve inpatient care. This prejudicial practice may be unique in its application to autism and likely violates mental health parity laws.

Acknowledgments

This project of the Autism and Developmental Disorders Inpatient Research Collaborative (ADDIRC) was supported by the Simons Foundation and the Nancy Lurie Marks Family Foundation (SFARI #296318 to M.S.). Dr. McGuire was supported in this work by a NIH T32 (Grant 5T32MH016434-35), a New York State Office of Mental Health Policy Scholar Award, and a Whitaker Scholar in Developmental Neuropsychiatry Award. Dr. Mazefsky was supported in this work by R01HD079512 and NICHD K23HD060601. The authors wish to thank the many children, families, administrators and staff members who they have worked with in the inpatient setting. All of the authors are employed by organizations that operate specialized inpatient child psychiatry units.

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