Treating Severe Behavior or Psychiatric Crises in Autistics Admitted to Emergency Medical or Inpatient Psychiatric Settings: It Is More than Just Reducing Behavior

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TARJAN CENTER AT UCLA
Lecture Series

Outline for Today

1. Brief Background on Acute Psychiatric Needs for ASD/IDD Persons
   - ASD-specific units vs. general psychiatric/ED units
   - Barriers, Strengths, Needs
2. Methods of Assessment/Treatment in Acute Settings
3. Basic Strategies to use in general acute settings that ASD non-specialists can use

Psychiatric Healthcare Crisis

1. The estimated total healthcare costs for ASD community in 2015 was $268 billion (Zuvekas, 2021)

2. 70.8% of ASD persons have problems behaviors/psychiatric needs (Simonff et al., 2008)

   – Approximately 10-15% will need inpatient psych services at least once during lifespan (Mandell, 2008; Tromans et al., 2018)

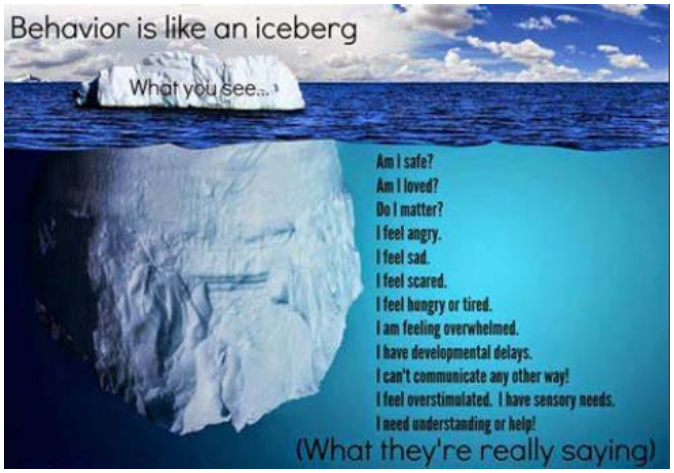
3. Psych: Increased rates/costs compared to non-ASD
   – Child: 11.9 times as many psych hospital stays; 12.4 times cost (Croen et al., 2006)
   – Adult: More likely to present to ED for psych reasons (12%) vs non-ASD peers (2%) (Kalb et al., 2012)

Common Difficulties in ASD Community that Increase Vulnerability for Behavioral Health Challenges

1. Communication Difficulties
   - Receptive Language
   - Expressive Language

2. Social Difficulties
   - Reduced Interest in Social Approval
   - Theory of Mind Deficits

3. "Co-occurring" Difficulties
   - Inattention
   - Hyperactivity
   - Irritability
   - Anxious/Fearful
   - Undiagnosed/untreated medical concerns



McClintock, Hall, Oliver, 2003; Baghdadli, Pascal, Grisi et al., 2003; LeCavalier, 2006; Matson, Fodstad, Rivet, 2009;

Additional Factors

1. Most often long history of behavioral difficulties
   - 20% of ASD children under age 2 display SIB or aggressive/disruptive behaviors (Fodstad et al., 2012)
   - 40% of ASD children under age 2 display fear, inattentiveness, hyperactivity, or irritable behaviors (Fodstad et al., 2010)
2. Caregiver burden/distress (LeCavalier et al., 2006)
3. Services at all levels (preventative, crisis) are limited compared need
4. Hospitals/Behavioral Healthcare services mis-match
   - 82% of general inpatient psych staff feel unprepared to care for ASD patients, yet 98.5% felt being able to provide acute psych care for ASD patients was necessary (Fodstad et al., 2020)

Predictors of Psychiatric Hospitalization - CHILD

Mandell, 2008:

1. Aggressive behavior (odds ratio (OR) = 4.83)
2. Single parent homes (OR = 2.54)
3. Depression (OR = 2.48)
4. Self-injurious Behavior (OR = 2.14)
5. Obsessive Compulsive Disorder (OCD) (OR = 2.35)

** Risk for Hospitalization Increases with Age

Righi et al., 2018; - Compared to ASD non-inpatient sample:

1. Mood Disorder (OR = 7.01)
2. Sleep problems (0.27)
3. Others: lower adaptive functioning, greater ASD severity, single parent home, severity of adaptive deficits, severity of ASD symptoms

Predictors of Psychiatric Hospitalization - ADULT

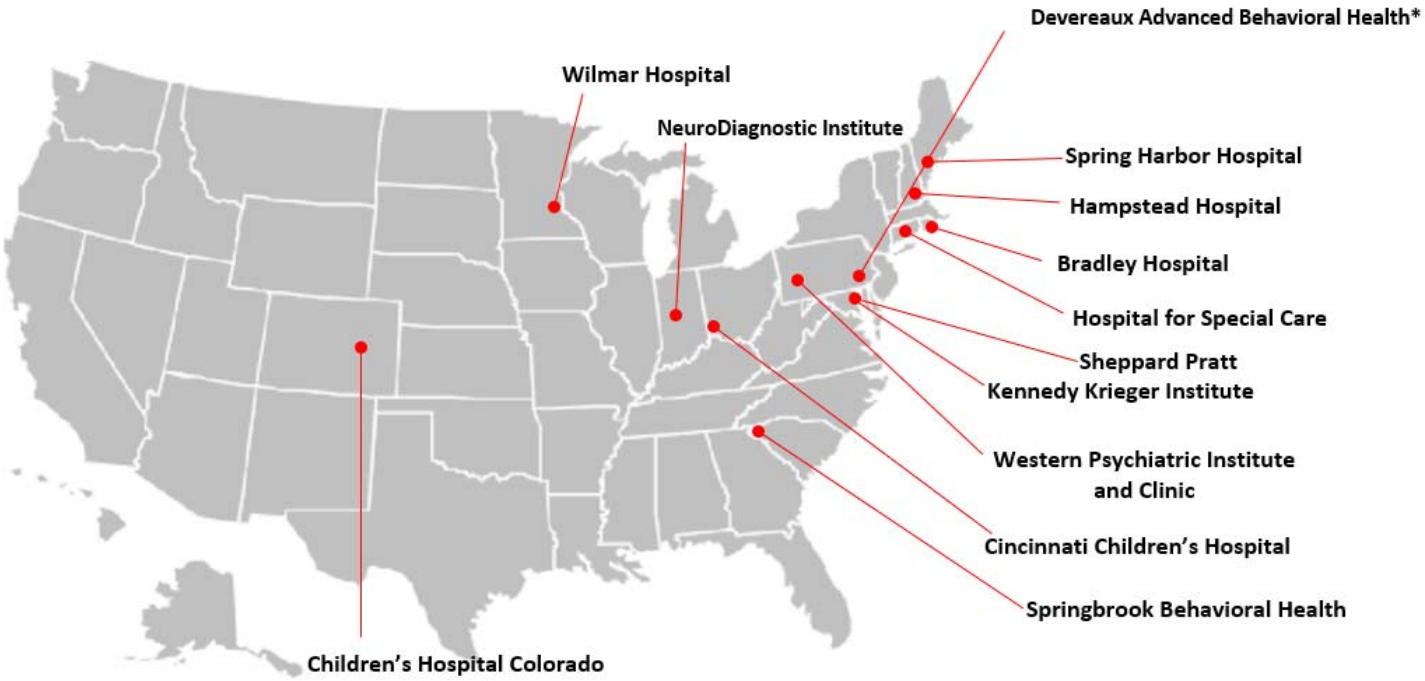
Lunsky et al, 2017:

1. Family distress (OR = 1.4)
2. Negative life events (OR = 2.8)
3. Being on psychotropic medication (OR = 6.7)
4. Aggression – towards self/others, including SI (OR = 4.8)
5. Immigrant-status/immigrant family (OR = 2.8)

Palucka & Lunsky, 2007:

1. Severe autism symptoms
2. Co-occurring ID
3. Mood Disorder
4. Physical Aggression

ASD-specific inpatient psychiatry/behavioral health units



Non-specialized Programs

Strengths

- Less wait time than ASD-specific units
- Partnerships with CMHCs
- Similar struggles as neurotypical peer patients
- Respite for families in crisis
- Monitor medication changes unlike in outpatient settings
- Experienced in broad array of psychiatric disorders which co-occur with ASD

From *Fodstad et al., (2021); Fodstad et al (in preparation)*

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Barriers

- Patient-specific:
  - Unique communication needs
  - Possible fear/sensory overload
  - May need increased staffing
  - Safety concerns/behavior problems
- Unit-specific:
  - Space constraints
  - Inability individualize programming
  - Minimal resources
  - High verbal/social demand programming
  - Stay may be too brief
- Staff-specific:
  - Limited ASD training
  - Fear/nervousness
  - Not prepared

From *Fodstad et al., (2021); Fodstad et al (in preparation)*

Needs of Non-specialized Programs

Parents

- Better understanding of ASD and individual needs
- Increase parent involvement and communication
- ASD-friendly resources
- Reduce wait times
- Accommodate sensory needs
- Individualized care approach
- Clear care plan at discharge that encompasses all concerns

From *Fodstad et al., (2021); Fodstad et al (in preparation)*

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Parents

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- Individualized care approach

Staff/Administrators

- Ongoing training
- Consultation with ASD providers
- Better understanding of ASD and individual needs
- More resources
  - Higher staffing model
  - Therapeutic/sensory
  - Visual aids
  - Communication support

From *Fodstad et al., (2021); Fodstad et al (in preparation)*

Needs of Non-specialized Programs

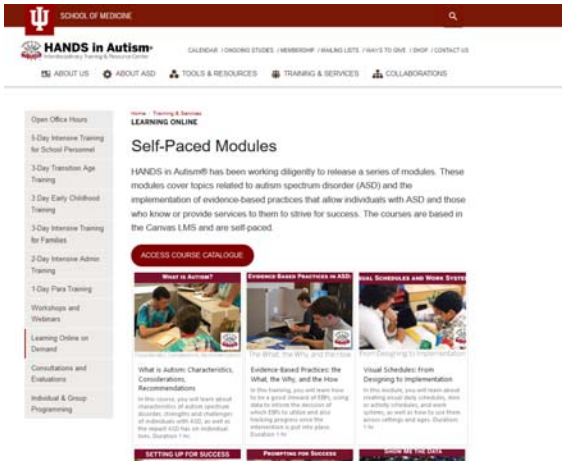
Parents	Staff/Administrators	Autistics

• Better understanding of ASD and individual needs and strengths
• Increase parent involvement and communication
• ASD-friendly resources
• Reduce wait times
• Accommodate sensory needs
• Individualized care approach
• Assess for contributing factors
	• Ongoing training
	• Consultation with ASD providers
	• Better understanding of ASD and individual needs
	• More resources
	  • Higher staffing model
	  • Therapeutic/sensory
	  • Visual aids
	  • Communication support
		• Better understanding and appreciation of the person
		• Accommodations for sensory needs/overload
		• Clear support or therapeutic materials
		• Involvement in care
		• Communication supports
		• Reduce waiting/transitions
		• “Recognition that its not just due to me being autistic”

From *Fodstad et al., (2021); Fodstad et al (in preparation)*

Where To Begin

INCREASE ACCESS TO AUTISM-AWARE PSYCHIATRIC CARE



GUIDELINES OR PROTOCOLS THAT CAN BE IMPLEMENTED IN FAST-PACED HEALTHCARE SYSTEMS

Fodstad et al. (in preparation)

Assessment and Treatment Targets

Adapted from McGuire et al 2015; Fodstad et al (in preparation); Kuriakose et al., 2018

Step 1: Initial Admission

Behavioral Health Intake Questionnaire

Name of parent/caregiver providing information: <free text>

Date: <date> Time: <time>

Name your child likes to be called: <free text>

Developmental/Cognitive Level: <free text>

Is your child receiving any services at this time? (Medicaid waiver, therapy, behavioral therapy, first steps, etc.)
<free text>

How does your child react to new people/strangers?
<free text>

Does your child have difficulty moving between activites, people or new environments? ☐ Yes ☐ No
If yes, please explain: <free text>
Does your child get easily agitated, aggressive or engage in self injurious behavior? ☐ Yes ☐ No
Ex. Spitting, hitting, kicking, biting, throwing objects, head banging
If yes, please explain behavior: <free text>

What are your child's triggers and signs of distress?
<free text>

What helps calm your child?

☐ Weighted blanket	☐ Electonic tablet	☐ Other <free text>
☐ Music	☐ Arts/Crafts	
☐ Action Heros	☐ TV/Cartoons	

What is the best way to communicate with your child?

☐ Pictures	☐ Sign Language
☐ Checklists	☐ Communication Device
☐ Words	☐ Other: <free text>

How does your child tell us what they need?
☐ Words

Step 1: Initial Admission

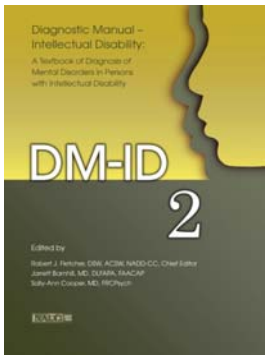
1. Expeditious Care
2. Reduce Environmental Triggers
   - (See, Hear, Feel, Speak; Samet & Luterman, 2019)
3. Provide Early & Clear Information on Expectations/Options
4. Clearly Communicate Specific Needs to Providers
5. Resource Library
6. Support the Autistic Person's & Caregiver's Needs

Step 2: Screen for Medical Etiology

1. High correlation between behavioral health needs and medical concerns (Cohen & Tsiouris, 2020; Courtemanche et al., 2016; Guinchat et al., 2015)

2. Greater prevalence of:
   - Neurological Disorders (10-30% have epilepsy; Pacheva et al., 2019)
   - Sleep difficulties/disorders (80%)
   - GI Problems (46-85% with 5-30% experiencing constipation; Holingue et al., 2018)
   - Metabolic Disorders (Cheng et al., 2017)
   - Immune, Autoimmune, and allergic disorders (25% of ASD children have immune deficiency/dysfunction; Gladysz et al 2018)
     - The curious case of autoimmune encephalitis

Step 3: Assess for and Treat Co-occurring Psychiatric Disorders



1. High prevalence of psychiatric disorders in ASD and ID

2. Assessment Process
   - Caregiver/patient interview or observation
   - Account and adjust for communication abilities/preferences, cognitive difficulties, developmental level, and features typical of ASD or ID
   - Interpret standardized measures with caution
   - Use evidenced-based pharmacotherapy
   - Contact ASD specialists in system as needed

Be Happy
Indiana Behavioral Health Access Program for Youth

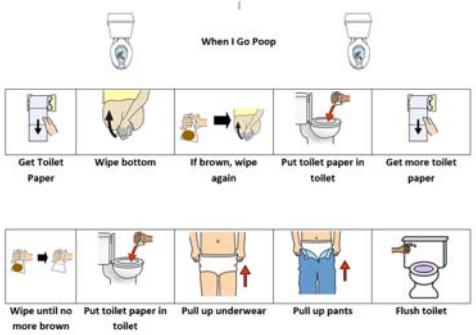
PHARMACOTHERAPY accp

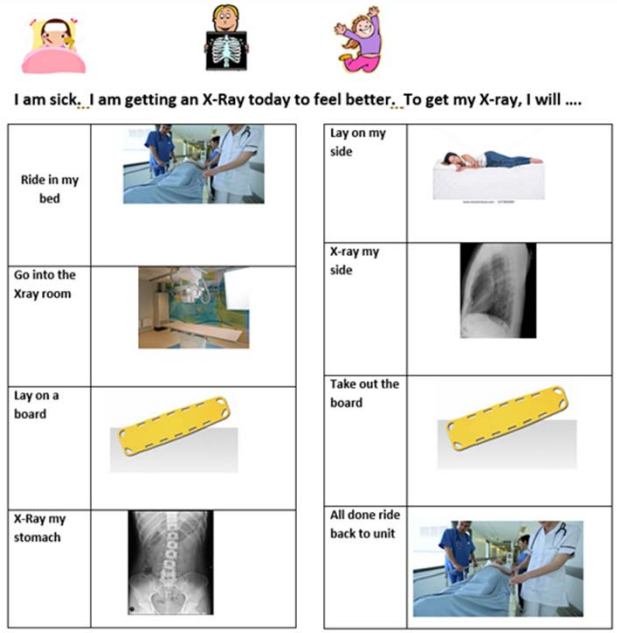
Original Research Article | Free Access

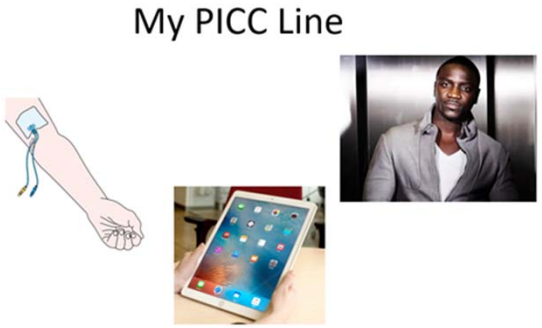
Pharmacotherapy of Autism Spectrum Disorder: Results from the Randomized BAART Clinical Trial

C. Lindsay DeVane, Jane M. Charles, Ruth K. Abramson, John E. Williams, Laura A. Carpenter, Sarah Raven, Frampton Gwynette, Craig A. Stuck, Mark E. Geesey, Catherine Bradley ... See all authors

Step 4: Support Communication, Sensory, Motor, Medical, and Self-Care Needs







Step 5: Conduct Behavioral Assessment

Indirect Assessment

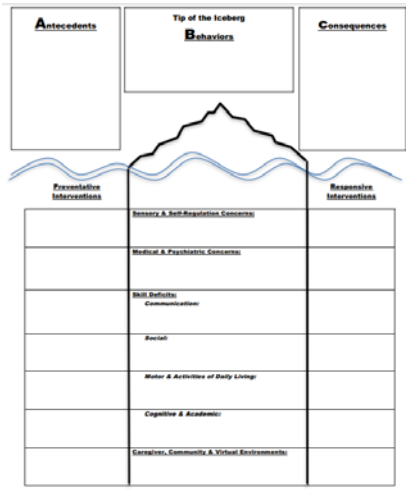
FUNCTIONAL ASSESSMENT SCREENING TOOL (FAST)

Name:_____ Age: _____ Date: _____

Behavior Problem: _____

Informant: _____ Interviewer: _____

To the Interviewer: The Functional Analysis Screening Tool (FAST) is designed to identify a number of factors that may influence the occurrence of problem behaviors. It should be used only as an initial screening toll and as part of a comprehensive functional assessment or analysis of problem behavior. The FAST should be administered to several individuals who interact with the person frequently. Results should then be used as the basis for conducting direct observations in several different contexts to verify likely behavioral functions, clarify ambiguous functions, and identify other relevant factors that may not have been included in this instrument.



Behavior Assessment and Intervention Summary Sheet

From Gabriels and Barnes, 2012

Observation/In Vivo Data Collection

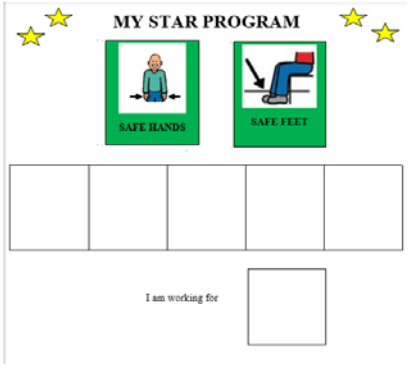
Date:	Time:	Activity in Progress:	Intensity and Duration
Antecedent: __Given direction/task/activity __New task or activity __Difficult task or activity __Waiting __Preferred activity interrupted __Activity/item denied (told no) __Loud and noisy environment __Given a correction __Transition __Attention given to others __Presence of specific person __Attention not given when wanted __Alone (no activity) __Alone (no attention) Other: _____ _____	**Behaviors:** __Refusal to follow directions __Verbal refusal __Making verbal threats __Crying/whining __Screaming/yelling __Scratching __Biting __Kicking __Spitting __Flopping __Running away __Destroying property __Flipping furniture __Hitting self __Hitting others (students) __Hitting others (adults)	**Consequences:** __Verbal redirection __Physical prompt __Ignored problem behavior __Kept demand on __Used proximity control __Verbal reprimand __Removed from activity/location __Given another task/activity __Response block __Left alone __Loss of privilege __Calming spot __Peer attention __Time out (duration)_____ __ asked to leave the room	**Intensity:** __ Low __ Medium __ High Duration: __ < 1 min. __ 1-5 min. __ 5-10 min. __ 10-15 min. __ 15-30 min. __ 30 min.- 1 hr. __ 1-2 hrs. __ 3+ hrs.

Step 6: Adapt environment and programming

Star Program – Inpatient Zones

Patient can earn up to two stars for each time slot. Patient can purchase an activity or reward from his/her "Star Rewards" Menu when the Bank is Open. If Patient is actively having a behavioral episode at the time of reward cash-in, no stars may be redeemed. Points earned in the morning can roll over to the afternoon / evening if they are unused. Each day starts back at zero-star points.

Time	Activity	Follow Directions	Keep my Hands and Feet to Myself
8:00 am – 9:00 am	Breakfast Vitals, Meds Goals with Staff		
9:00 am – 10:00 am	School		
10:00 am – 10:15 am	Snack		
10:15 am – 10:45 am	Zones Group		
10:45 – 11:15 am **Reward Time**	**Total Stars Earned:**	**Reward Chosen:**	



My Daily Schedule

Time	Activity	Picture
830A	Vitals	
900A	Goal Group	
9-10A	Enrichment Activity with Staff	
10-11A	Art Therapy	
11A	Snack	
11A-12P	Zones Group	
NOON	Lunch	
1-130P	Ipad Time	
130-215P	School	

Step 7: Additional Considerations

1. Incorporate structured educational services to facilitate transition back to school (if school-age)
2. Outside of ongoing training of staff, provide adaptable resources that can be used as needed upon admission
3. A longer length of stay may be needed to facilitate behavior change, generalization, multidisciplinary, caregiver training, and care coordination work
4. Reconsider medical necessity for inpatient psychiatric care
5. Involvement of autistic patient and/or caregiver in treatment during stay

Summary

1. Acute psychiatric care can be successfully provided in non-specialized medical settings

2. Adaptations must occur to increase access to person- and family-centered care that best meets the needs, co-occurring symptoms, and unique profile of the autistic patient

3. Staff need additional resources and ongoing training and consultation to feel confident in their ability to provide high quality psychiatric care to autistic patient

Questions?

Feel free to email me at: jfodstad@iupui.edu

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