Putting the Puzzle Together: Inpatient Treatment of the Autistic Child

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What is Autism?

A pervasive developmental disability of unknown etiology that manifests in early childhood

What is ASD?

- Autism Spectrum Disorder
- DSM -5 criteria; all Autism diagnoses are under the umbrella of Autism Spectrum Disorder (ASD) & related Social (Pragmatic) Communication Disorder

Early Manifestations

- Neurotypical infants
- Infants with Autism Spectrum Disorder (ASD)

Prevalence & Incidence rates

- 4.5 more common in males than females
- 1 in 68 males has ASD
- 1 in 189 females has ASD
- ASD affects over 2 million people in the U.S. & tens of millions worldwide

Risk & Cause

- Risk & Cause are very different
- Genetics, environment, or a combination may increase risk of ASD
- No one cause has been identified. Rare gene changes/mutations have been associated

Common Traits Associated with ASD

- Hypersensitivities
- Feeding issues
- Communication challenges
- Difficulty interpreting social cues
- Every person with ASD is a distinct individual as we all are

Diagnosis

- There is no medical test to diagnose ASD
- ASD is diagnosed through a compilation of symptoms & requires an interdisciplinary team
- DSM -5 criteria; all Autism diagnoses are under the umbrella of Autism Spectrum Disorder (ASD) & related Social (Pragmatic) Communication Disorder

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Common Co-occurring Disorders & Diagnoses

- Anxiety disorders
- Mood disorders
- ADHD
- Depression
- GI disturbances
- Sleep disturbances
- Seizure disorders
- Eczema
- Asthma

Treatment Goals

Increase:

- Desirable behaviors
- Communication skills
- Socialization
- Self-care skills

Decrease:

- Disruptive/maladaptive behaviors
- Family stress
- Frustration experienced by the individual with ASD

Treatment

- Interdisciplinary approach is vital
- Behavioral therapy
- Psychopharmacology
- Education
- Sensory integration

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Treatment- continued

- Social-cognitive skill building
- Developmental skill based programs
- Relationship based interactive interventions
- Parent- mediated approaches/family therapy
- Complementary & Alternative Medicine (CAM)

Key Points

- Early intervention
- Reach & maintain the individual's optimal level of functioning
- Maintain consistency & structure

RI-CART

- R.I. Consortium for Autism Research & Treatment
- A joint initiative of Bradley Hospital, R.I. Hospital, Women & Infants Hospital, & Brown University
- Bringing together multiple research disciplines to allow new, innovative research

Case Study #1

- Danny- 17 year old male, multiple inpatient hospitalizations beginning at a young age
- Primary diagnosis(es) of ASD with associated Intellectual Disability: Stereotypic movement disorder with Self Injurious Behavior (SIB); Disruptive mood dysregulation disorder
- Medical Diagnosis: Celiac disease, GERD
- Currently admitted following 9 month residential placement; has been inpatient since May 2017

History of Presenting Illness

- Patient admitted from residential program in the context of progressively worsening behavior, including significant self-injury, medication refusal
- Patient presented as anxious, frequently engaging in SIB, as well as, self-induced vomiting with each meal. Vomiting had become particularly difficult to manage at residential facility; patient was nutritionally at risk.

Medical & Psychiatric History

Medical

- Celiac disease & GERD
- Eosinophilic esophagitis
- Duodenitis
- Osteomyelitis (secondary to self injury)
- Brodie Abscess

Psychiatric

- Four inpatient admissions to Bradley between August 2015 to July 2016, each lasting 2-6 months in duration
- Placement in residential facility in July 2016 until admission August 2017

Strengths & Challenges

- Significant family support and involvement
- Prior response to treatment
- Connections to outpatient services

- Isolation
- Social skills (deficits)
- Poor impulse control
- Functional impairment
- Medical impairment
- Academic learning difficulties
- Cognitive deficits
- Language/communication

Interdisciplinary Treatment

- Care team lead by attending psychiatrist in collaboration with Nursing team
- Occupational and Speech Therapy indicated for this patient, provide an integrated treatment plan
- Clinical nutritionist
- Psychology & Behavior Specialist
- Social Work
- Close consult with pediatrics

Ethical Consideration

Intersection of medical treatment and behavioral treatment

Use of protective equipment as a behavior intervention (i.e. soft helmet and arm splints)

Collaboration with family and making agreements about treatment

Discharge planning for best outcomes and quality of life

****Planning for discharge

Case Presentation Two: GP

- GP is 20 year old male, who presents for aggression towards grandmother, elopement, as well as self-injury.
  - Patient attempted to purchase gun because grandmother was "too old" and it was time for her "to go".
  - Patient recently discovered that the uvula has no medical necessity and has been attempting to remove his uvula.
  - Patient will elope from home in the night to go into the city and look at elevators.

Previous Diagnosis(es) and Prescribed Medications

- Diagnosis:
  - Anxiety, Autism (ASD), Obsessive Compulsive Disorder (OCD)
- Medications:
  - Clonezapam, 0.5 mg- 3x Day
  - Propanolol, 10mg- 3x Day
  - Quetiapine, 150mg- 2x Day
  - Benadryl, 50mg- PRN
  - Lorazepam, 0.5mg- PRN up to 3x day

Asperger's Syndrome?

Asperger's Syndrome was taken out of the DSM-5

You will now see Asperger's falling under the ASD umbrella

Some patients identify strongly with their diagnosis and will still self identify as having Asperger's vs. ASD

History of Present Illness

- Patient has been known to HCO for over three years due to needing previous inpatient hospital stays as well as in home supports around his ASD and OCD symptoms

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Past Psychiatric history

- Patient has required multiple inpatient hospitalizations due to his perseverations in the past.
- When upset patient will yell, engage in self injurious behavior and become destructive.

Past medical History

- No major medical issues
- History of a broken foot, chronic ear infections, chronic sinus infections and allergic rhinitis.

Social/ Family history

- Patient lives with dad and step mom (together 8 years, married 4).
  - Dad has history of depression, recent back injury resulting in loss of job
  - Biological brother has ASD as well and lives in a group home
  - Biological Mom involved earlier in patients life- has been out of patients life for many years. Reported she has history of substance abuse issues
  - Step mom with history of mental illness- reports of throwing objects at patient and being verbally abusive resulting in BHDDH report
  - Family has struggled with housing insecurity due to fathers job loss
  - Due to patients age DCYF can not provide services nor can adult services.

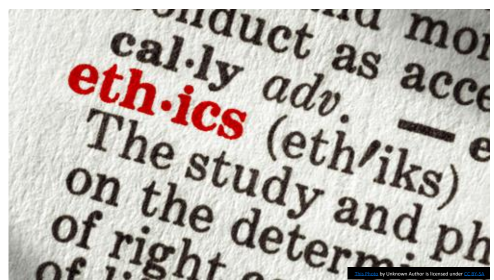
Social/Family

- Patient attends a therapeutic school focusing on life skills and will graduate at 21
- Pt reports he enjoys school but becomes upset when other students will not conform to his rigid requests (i.e. clothing choices).
  - Father reports it is difficult for patient to maintain friendships.

Interdisciplinary Care Considerations

- Social Work
  - Social work needs were significantly greater specifically securing housing (in earlier admissions) and later a group home placement for patient
  - Social work was a key partner in this patients care as the patient had so many social needs
- Occupation Therapist
  - Due to the patient preservations and rumination of thoughts, OT consulted and provided coping skills training
- Applied Behavior Analyst
  - Behavioral support team provided skills to help the patient accept changes such as a now next schedule, and earning structured "cash-ins" for good behavior.

Ethical Considerations



Ethical considerations

- While dad was a dedicated caregiver he was unable to meet the patients long term needs in terms of safety and stability.
  - The team decided to recommend that patient be placed out of dad's care
    - With educational resources over time, Dad agreed.
  - The patients age presented some challenges in securing a group home placement resulting in a prolonged inpatient stay of over six months.
  - The team often had to balance what was best for the patient long term with this extended, long term stay in an inpatient psychiatric unit-

    We often questioned- *was this the right answer for this patient*?
    - Education?
    - Social experiences?
    - Community ties?

Interdisciplinary Care

How can RNs collaborate with other disciplines to deliver high quality care?

Questions?