Psychiatric hospitalization of children with autism spectrum disorder (ASD) and/or intellectual disability (ID) is common and challenging. Children with ASD are 6 times more likely to be psychiatrically hospitalized than children without ASD. Owing 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 might 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 might have impairments in social communication and cognitive abilities and also rigid routines and preferences. Specialized units have shown improvement in the behavioral functioning of children with ASD or ID 2 months after discharge and decreased readmissions in 2 uncontrolled studies with an average length of stay of 26 to 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 6 US specialized units convened. Owing to the limited amount of research in this 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 semistructured 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 used by specialized units and offer a vision of how best to serve this population. As such, the panel sought to strike a balance between identifying best practices and providing recommendations that can 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 used to assess and treat persistent unsafe behaviors (such as physical aggression or self-injury) and 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 ASD or ID. Inpatient treatment might be more successful when using specific accommodations and strategies, as detailed below.

**Obtain information specific to the child with ASD or ID and the child’s 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, and 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, or hair pulling). Self-care needs should be identified, including the ability to swallow medicine, and resources and challenges in the caregiver system should be assessed. Summarize important information in a tip sheet for direct care staff. Evaluate for contributors to problem 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 nonverbal. 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, and ear infections). Current medications, including over-the-counter or complementary and alternative substances, should be assessed for side effects,

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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 underdiagnosis 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 a 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 symptoms and irritability 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 (e.g., glasses, weighted blanket) supports 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 the use of visual activity schedules and alternative communication systems (e.g., picture exchange communication systems or augmentative and alternative communication devices).

Conduct a behavioral assessment and collect data on observable target behavior
Children with ASD or ID are typically hospitalized because of observable externalizing behaviors. Assessment of the function of the behavior, based on 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 the treatment response and train them in the behavioral plan to facilitate generalization after 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 owing 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 or 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, 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., National Association for the Dually Diagnosed Competency-Based Direct-Support Professional Certification Program). It might be most sustainable to train a subset of staff motivated to work with this population.

A longer inpatient length of stay might be beneficial for changing patterns of externalizing behavior and facilitating generalization and multidisciplinary work
A longer stay might be necessary 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. Insurance usage 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 homicidal tendencies, suicidality, or failure to care for
oneself. The risk of denial of care increases if these criteria are inappropriately applied to this population, whose intent of physical aggression or self-injury sometimes cannot be determined owing to communication challenges and who might not be able to 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 oneself or others or a decrease from baseline in the ability to care for oneself is a more appropriate criterion. Insurance companies also might insist that another psychiatric disorder be present, in addition to ASD, to approve inpatient care. This prejudicial practice might be unique in its application to ASD and likely violates mental health parity laws.

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