United States, et al. v. Commonwealth of Pennsylvania. Civil Action No. 93-CV-2094. April 21, 1993.
United States, et al. v. Commonwealth of Pennsylvania, Stipulated Agreement, Order of March 21, 2000.
Yando, R. (1999). Report of Site Visits, Embreeville Providers, Pennsylvania.
Yount, R. (2002). Psychology Findings. In Records, T (2002), Special Report to the parties Regarding Compliance with the Stipulated Agreement.

Corresponding Author:
Amy Nemirow, Ph.D.
Philadelphia Coordinated Health Care
anemirow@pmhcc.org

A Psychiatric Inpatient Unit

The Establishment of a Psychiatric Inpatient Unit for Children and Adolescents with Developmental Disabilities

Desmond Kaplan, MD, Samantha Berthod, BA, Luther Kalb, BA, Tonisha Drummond, Catherine Braun, BS, Abode Akinton, MD, Nilda Gonzalez, MD, Kathleen Koth, DO, Richard Kunkel, LCSW-C, Kristi Auman, BS, Jean Knight BA, Sara Colbert, BA, and Vassilis E. Koliatsos, MD, The Sheppard and Enoch Pratt Hospital

Introduction

A model program for a multidisciplinary 12 bed inpatient unit, for coed children and adolescents 6 to 19 years, diagnosed with a developmental disability and a mental illness, was successfully established at Sheppard Pratt in Baltimore, MD in October 2002. As we embark on the unit's 4 year anniversary, we review its establishment, current level of functioning, and future directions.

Establishment

In August of 2002, following an 18 month planning period, the Sheppard and Enoch Pratt Hospital, a free standing psychiatric hospital in Baltimore, Maryland, established over 150 years ago, and affiliated with the University of Maryland, decided together with the Maryland Department of Health and Mental Hygiene, to develop a one of a kind program for a long underserved population. Our unit incorporates a full range of treatment for individuals with intellectual disabilities while at the same time creating a learning environment for staff and students alike.

A developmental disability interferes with the effective assessment of other symptoms as well as response to treatment of the patient. The use of interdisciplinary treatment teams allows for optimum treatment modalities. However, the success of a team depends largely on the cohesiveness of the group. Members from various disciplines must be able to coordinate their expertise and efforts. Therefore, the goals for the treatment team on the unit include the development of effective treatment plans unique to the individual, conducting a multidisciplinary assessment, and monitoring treatment outcomes. These goals are addressed at hour long team meetings held daily at which each patient's progress is discussed.

In July of 2005, we relocated to the new Sheppard Pratt hospital building to a specially designed 12 bed unit and two swing beds for a maximum capacity of 14. The Unit is equipped with an observation suite for behavioral assessments and interventions and private bathroom-en-suite rooms for each patient.

Three primary Program goals were set for the Unit; (a) to create an integrated multidisciplinary team to form a community of staff and patients working on the full spectrum of a patient's bio-psycho-social, educational and spiritual needs; (b) to provide an average length of stay of 21 days, owing to the complexity of problems; and, (c) to obtain, due to the two previous goals, a higher daily rate from private and state providers.

Current Status

Patients treated on the unit include children and adolescents ages 4 to 21 with a psychiatric disorder and/or maladaptive behaviors that make them unsafe to self or others, and a neurologic and/or genetic condition. Diagnoses represented by our patient population have included Mild to

1/3

Severe Mental Retardation, Autism, Asperger Syndrome, Pervasive Developmental Disorder, Cerebral Palsy, Spina Bifida, Fragile X Syndrome, Rett Disorder, Down Syndrome, Prader-Willi Syndrome, Turner Syndrome, Lesch-Nyhan Syndrome, Tuberous Sclerosis Complex, Kleinfelter Syndrome, Velo-cardio-facial Syndrome, and Cornelia deLange Syndrome.

Our unit is gaining increased recognition with the number of out-of-state referrals rising. For the unit to be successful, treatment options must be as diverse and complex as the population itself. The unit uses an empirically validated multidisciplinary approach and has maintained a higher patient to staff ratio than would be found on a traditional inpatient unit. Staff includes two child and adolescent psychiatrists with specialized training in developmental disabilities, a behavioral psychologist with extensive training in developmental disabilities and applied behavioral analysis, two social workers, an occupational therapist, a special education teacher, a speech and language pathologist, a discharge planner, psychiatric nurses, and behaviorally trained mental health workers. There are weekly consultations by a pediatrician and weekly teaching rounds by a neuropsychiatrist. In the future, we are open to inviting alternative treatment modalities such as art therapies on to the unit.

Treatment includes careful medication trials including medication "wash-outs," behavioral interventions, environmental assessment, communication training, and caregiver training. When appropriate, an individualized behavior plan and a transitional education plan are developed to assure that treatment goals may be sustained upon discharge. The team's goal is to integrate a strong behavioral component with pharmacological treatments.

Patients may undergo a systemic behavioral assessment to identify problem behaviors, including a functional assessment, to determine whether behaviors are motivated by need for attention, escape, tangible conditions or automatic/internal triggers. It should be noted that mental health workers gather data on all patients throughout the day (and at night if necessary), guiding the pharmacological and behavioral management of our patients.

Activities during the day include occupational therapy, speech therapy, school, therapeutic groups and recreational groups including music and gym. We also promote openness to alternative treatment modalities including art therapies. A weekly spiritual group for staff and patients is led by the hospital chaplain to increase morale on the unit.

Future Directions

Keeping behavioral intervention as a central modality of treatment is a challenge as well as dealing with the trend away from seclusion and restraint. Part of effectively addressing challenges requires that we identify and make better use of our strengths. While establishing the unit, it was essential that we created an academic environment open to learning, teaching, and staff development. A particular focus of our program that sets us apart is training of different professionals who treat this population, particularly psychiatrists in residency or fellowship training. For example, it is not uncommon to have 3 to 5 students of different disciplines completing internships. We have also stressed the concept of a "learning community" with weekly in-services/lectures, reviews of the literature and participation in conferences in an attempt to remain "cutting edge".

Professional and personal nurturing of every team member is a central principle of our unit's establishment. We strive for stability among our staff. Staff retention is a consistent challenge on a unit of this nature. Therefore, it is vital to maintain high morale among staff in spite of the possibility of physical danger when working closely with patients.

We consider parents and caregivers to be crucial members of our team. One of the main goals we plan to focus on in the future is to increase the involvement of the parents or care giver in forming, working on, and continuing our treatment plan. It is the role of the interdisciplinary team to aid in educating the parents on their child's condition and how best to interact with him or her (Vig & Kaminer, 2003). An important indicator of how effective a patient's outlook has been after discharge is how much the parent has been incorporated into treatment. However, this is easier said than done and more intensive work is needed. We hope to include more sophisticated methods of family intervention by forming a partnership with care givers and create a support group for parents.

Parents and staff are not the only team members we can look to for making improvements on the unit. In order to provide optimum care for children with dual diagnosis, it is necessary to educate managed care organizations and private insurers about the necessity for having our unit. A better understanding of the reasons for funding a treatment facility specially designed to address the needs of children with a dual diagnosis

will help to ease financial pressures and allow us to provide the most favorable length of stay for the patients on our unit.

Longer lengths of stay are required. Initially 21 to 28 days on the unit is planned, but patients average a stay of 15 days. Sovner (1995) categorizes length of stay according to the goals of hospitalization and addresses the need to cater length of stay to each individual's requirements. The first step in obtaining this goal would be to establish a clinical baseline by way of structured neuropsychological testing as a requirement for each patient upon admission. Over time, we hope to address the above issues to offer the best available treatment options for the population we serve and act as a model for future inpatient units of its kind.

Corresponding Author:
Desmond Kaplan, M.D.
Sheppard Pratt Hospital
6501 N. Charles St.
Baltimore, MD 21204
410-938-4762

References

Coleman, J. C., & Paul, G. L. (2001). Relationship between staffing ratios and effectiveness of inpatient psychiatric units. Psychiatric Services, 52, 374-1379.

Farrell, S. (1991). The interdisciplinary team process in developmental disabilities. *Developmental disabilities in infancy and childhood* (pp. 209-217). Paul H. Brookes Publishing.

Guralnick, M. (2000). *Interdisciplinary clinical assessment of young children with developmental disabilities.* Paul H. Brookes Publishing.

Kaplan, D. M., et al. (2005). An acute psychiatric in-patient unit for youth with developmental disabilities. NADD Conference, 28-29.

Singh, N., Wahler, R., Sabaawi, M., Goza, A., Singh, S., & Molina, E.(2002). Mentoring treatment teams to integrate behavioral and psychopharmacological treatments in developmental disabilities. *Research in Developmental Disabilities. 23*, 379-389.

Sovner, R., (1995). How long should a psychiatric inpatient stay be for a person with developmental disabilities. The Habilitative Mental Health Care Newsletter, 14(1).

Vig, S., & Kaminer, R. (2003). Comprehensive interdisciplinary evaluation as intervention for young children. Infants & Young Children. 16, 342-353.

Woolston, J.L. (2002). The Administration of Hospital-Based Services. In. J. Schowalter (Ed.), *Administrative Psychiatry. Child and Adolescent Clinics of North America, 2,* 43-65.

Role of Theoretical models

The Role of Theoretical Models in Developing Cross-Cultural Counseling Strategies

Kate Scorgie, Ph.D., Azusa Pacific University
Lorraine Wilgosh, Ph.D, University of Alberta

Recent research on parent coping and adjustment following diagnosis of disability in a child is drawing attention to the importance of culture as a key variable in how families manage life following diagnosis (Mary, 1990; Watanabe, 1998). Culture provides a framework for interpreting and assigning meaning to life events. Therefore, rather than assuming universality of reaction to diagnosis, it is important for professionals to consider cultural context in family coping and outcome (Ingstad, 1988). For example, Alston and Turner (1994) maintained that African-American family adjustment following stress events incorporates cultural themes, such as strong religious beliefs, intergenerational family bonds, role flexibility and sound work ethic. Similarly, in a study of African American, Hispanic, and Caucasian mothers' response to diagnosis of disability, Mary (1990) found both commonalities and differences across cultures, emphasizing the need to further examine the effects of culture on family life management.

McCallion and Janicki (1997) assert that while it is valuable for professionals to consider cultural variations in family adjustment to diagnosis of disability, it is important to avoid stereotyping families from particular minorities. Though families are situated within a culture that influences perception of and response to diagnosis of disability, each family is unique, shaped by the experiences, values and beliefs of each member.

3/3