Significant Achievement Awards

A Comprehensive Program for Treating Profoundly Autistic Children—Center for Autistic Children, Philadelphia

The Center for Autistic Children in Philadelphia was the first clinic in the country to specifically treat autism. From modest beginnings in 1955 as a state grant-funded demonstration project of the University of Pennsylvania, the center has evolved into a private, nonprofit, outpatient clinic that today provides highly specialized treatment and services to low-income families in Pennsylvania, New Jersey, and Delaware.

The center's deceptively simple name belies the scope of its programs and services. Besides providing diagnostic evaluations and intensive treatment to children who are autistic, atypical, or pervasively developmentally delayed or who have severe emotional disturbances and severe communication problems, the center also serves adolescents and adults through weekly in-house therapy sessions.

Wraparound services reach autistic children in the home, at school, and in day care centers. Year-round programming is available for children age three to 15. The summer program includes additional children within a therapeutic recreation format that permits a transition period for children who will be leaving the center for school in the fall and for children entering the program.

Clinical and professional outreach programs serve parent groups, other mental health agencies, and area school districts. Community education is an ongoing commitment.

The center is a lifeline for families and caretakers. The family support program trains and involves the family in the child's treatment process and assists families in keeping their child at home and in the community. Parents and caregivers are provided with support in coping with their own stress and feelings of isolation. On "Family Days," staff and families meet in a relaxed atmosphere to share food and activities. Emergency financial support is available. Client satisfaction surveys ensure that the center is meeting the needs of both child and family.

Under the direction of Bertram A. Ruttenberg, M.D., the center's founder, president, and medical director, and Jean Ruttenberg, M.A., its executive director, the center operates with a staff of approximately 50 professionals, including a clinical director; consulting professionals in the fields of psychiatry, psychology, occupational therapy, and speech pathology; program coordinators; mobile therapists; a social worker; and mental health therapists. The staff's diversity of specializations reflects the center's multifocus approach to treatment. Individual goals are set for each child using contextual observation to assess developmental levels, sensory needs, and behavioral patterns. These goals are then addressed through a consistent and predictable daily structure.

A primary treatment goal is to provide the child with a viable communication system. Working on the assumption that strange behaviors and maladaptive social functioning are secondary characteristics that result from the child's efforts to cope with the demands of his or her environment, the center's approach is to carefully analyze discrete behaviors to determine how they function for the child. The conventional concept of language is broadened to include any form of communication that may convey intent—bodily contact, proximity, bodily orientation, appearance, posture, head movements, facial expressions, gestures, and looking or eye contact as well as nonverbal aspects of speech such as pitch, stress, timing, and volume. Once the communicative intent of the behavior is understood, staff help reshape the behavior into something more appropriate and generally understandable. The program model is consistently modified to incorporate innovative research findings and technology.

A significant contribution by the center to the mental health field is the introduction of the Behavior Rating Instrument for Autistic and Atypical Children (BRIAAC), a testing instrument specifically geared toward autism-spectrum disorders. Developed in 1966 after 15 years of rigorous study and research, the test is the prototype for many of the tools currently in use. The BRIAAC assesses the child's present levels of functioning and measures changes in eight key areas. Regardless of a child's inability to cooperate in the testing process, the BRIAAC produces meaningful results that help determine the child's emotional and educational needs and facilitates program planning.

The center played an important role in two landmark legal cases whose outcomes have helped improve the quality of life for autistic and other severely handicapped persons in Pennsylvania and nationwide. In *Armstrong v. Kline*, Dr. Ruttenberg's expert testimony on behalf of one of the center's clients heavily influenced the outcome of the decision, which resulted in an extended school year for severely handicapped children. In *Jackson v. O'Bannon*, the plaintiffs sought to extend the

number of hours for outpatient psychotherapy for severely handicapped populations allowed by Pennsylvania's Office of Medical Assistance. Dr. Ruttenberg was instrumental in convincing the court that intensive and extensive therapeutic work is crucial to achieving positive clinical outcomes with certain seriously disabled persons.

Participation by autistic and atypical children in the public school system is an ongoing concern as well as a goal for the center. Between 1977 and 1980, with funding from the U.S. Board of Education, the center developed Project LINK, an integrated, interdisciplinary psychotherapeutic program for young autistic children in school settings. LINK echoes the center's own multifocus approach by combining the input of a child psychiatrist, a speech therapist, a sensory integration therapist, a music therapist, a movement therapist, an infant and early childhood education specialist, a parent liaison, a BRIAAC rater, and teachers to evaluate a child's developmental level. Programming for each child is then begun at his or her own individual level. This comprehensive approach addresses learning issues as well as the broader spectrum of communication, physical, intellectual, interactional, relational, and emotional needs. The LINK model has been replicated and used by school districts throughout the country.

Along with other health care providers, the center has felt the impact of managed health care. In 1997 the Pennsylvania Department of Public Welfare implemented HealthChoices, which required Medicaid recipients to enroll in a managed care plan instead of the state's fee-for-service plan. Many services that had been covered under one authorization now required several, and different services had different authorization periods. Faced with a decline in efficiency and service delivery under this cumbersome new system, the center developed specialized autism services (SAS), an intensive daily program for young children.

SAS simplifies the authorization process by integrating all services, specifying a unit of time and a reimbursement rate. A unit is equivalent to three hours, and a child may receive one or two units of service a day, depending on medical necessity. The program is a fully integrated service that includes evaluation, one-on-one therapy, group therapy, family services, medication management, case management, and transportation. With SAS, the center can respond quickly and creatively to the unique needs of individual children and their families without having to obtain new authorizations for specific services. The center bears the risk of the children's needs, so in many ways it is a capitated model of behavioral heath care delivery for autistic children.

The Center for Autistic Children is licensed by the State of Pennsylvania Department of Public Welfare and funded primarily by HealthChoices—the Pennsylvania Medicaid program—and the Philadelphia Office of Mental Health and Mental Retardation. Additional funding is obtained through grants from private foundations, donations, fundraising, and fees for service.

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A Model Prison Diversion Program—The Criminal Justice–Community Outreach Department of the Montgomery County Emergency Service, Norristown, Pennsylvania

The mentally ill population has a disproportionate involvement with the criminal justice system, with high rates of booking and incarceration, often for minor offenses resulting from behavior linked with treatable mental and substance use disorders. The Criminal Justice–Community Outreach Department of the Montgomery County Emergency Service was conceived in the 1970s to mitigate this situation by providing a team approach to identifying mentally ill individuals who have come into contact with the criminal justice system, stabilizing them in the least restrictive setting, and returning them to the community as soon as possible.

Montgomery County Emergency Service, incorporated in 1974 as a not-for-profit, freestanding psychiatric hospital, has 63 beds and offers a broad array of emergency psychiatric and drug and alcohol detoxification services. Approximately 90 percent of the hospital's patients live in Montgomery County, Pennsylvania. Available services include a crisis hotline, a walk-in service, emergency evaluation, inpatient care, aftercare planning, community outreach, mobile crisis intervention services, crisis residential services, criminal justice services, consultation, and education. The emergency service is also the designated provider for Montgomery County of services involving initial involuntary commitment and treatment, including delegate and mental health court services.

The Criminal Justice–Community Outreach Department has situated its program within the criminal justice system to provide an alternative to incarceration and to ensure that mentally ill offenders receive treatment. The program has been highly effective, reducing inpatient hospital days by nearly 20 percent and incarceration days by nearly 90 percent, and it has achieved national recognition as a model prison diversion program.

The program has evolved over the years, and today, operating with nine essential staff members, the department maintains six components: a criminal justice liaison, a forensic liaison, a mobile crisis intervention service, short-term intensive case management, long-term forensic intensive case management, and a forensic intensive case management diversion team.

The criminal justice component of the department provides liaison services for law enforcement agencies and the criminal justice system. Other services include community outreach, assessment, follow-up, and advocacy for persons with mental illness who become entangled in the legal system. Education and training are provided to staff of law enforcement and criminal justice agencies. The current director of the criminal justice component, Donald F. Kline, teaches at the police academy and assists Montgomery County crisis emergency response teams. The director also provides forensic diversion services—diverting consumers from the legal system and ensuring that they receive appropriate services—and troubleshoots systems problems between mental health, mental retardation, and substance abuse services and the criminal justice system.

The forensic liaison provides community outreach, assessment, and follow-up and tracks consumers who have become involved in the legal system. This office provides liaison services between the Montgomery County Correctional Facility and the emergency service and conducts on-site evaluations at the correctional facility, on a 24-hour basis, to identify consumers and ensure that they receive the appropriate care and treatment. The liaison officer also serves as consumer advocate, provides forensic diversion services for consumers involved in the legal system, tracks consumers with legal charges at the emergency service, and provides liaison services with the regional forensic unit.

The mobile crisis intervention service provides 24-hour services for persons with mental illness who are in crisis, at risk of hospitalization, and in need of treatment. The main focus of the mobile crisis intervention team is community-based intervention to promote the consumer's stability and avoid hospitalization. The service provides countywide community outreach and crisis intervention services to all persons in Montgomery County who need it. The mobile crisis intervention service also is licensed for mobile medical services in which a registered nurse provides medication and medical care. Other services provided include consumer advocacy, follow-up, education, and referral services.

The mobile crisis intervention service has an established track record of diverting individuals from the hospital setting. In the past five years the mobile crisis intervention team has provided services to 2,211 individuals and hospitalized only 110, or 5 percent. In the 12-month period from December 1998 to November 1999, the team made 1,961 consumer contacts and 508 community outreach contacts.

About 50 inmates are evaluated each week, and the department provides services for these consumers via the criminal justice, forensic, mobile crisis intervention, and intensive case management programs.

The short-term intensive case management program provides therapeutic and case management services and intensive follow-up for three to six months for persons with mental illness who are not covered by the traditional mental health system. Services include therapeutic and intensive case management services, consumer advocacy, and education. The goal of the program is to promote community-based treatment, ensure consumers' stability, and reduce recidivism. The program promotes community-based treatment to ensure that consumers connect with the traditional system.

The long-term forensic intensive case management program provides therapeutic and case management services to consumers who come into contact or conflict with the legal system. The program provides consumer advocacy and education, promotes community-based treatment, and ensures that consumers connect with the traditional system-mental health, mental retardation, or substance abuse services. Staff members maintain a close working relationship with staff from law enforcement agencies and the criminal justice system.

The forensic intensive case management diversion team is part of a federally funded study that includes nine sites across the country. The team focuses on the consumer's stability to improve clinical outcomes —symptoms, functioning, compliance, and so on—and to reduce prison recidivism and length of inpatient hospitalization. The team functions as a traditional intensive case management service and provides intensive therapeutic interactions, including medication maintenance and monitoring by a registered nurse. It also focuses on community-based treatment and integration of services, improvement in the quality of life of the consumers served, and reduction of substance abuse or dependency. Other services include legal advocacy and education.

The Criminal Justice–Community Outreach Department can manage 75 high-risk, problematic, severely mentally ill consumers who have co-occurring disorders on the short-term and forensic intensive case management caseloads. In the 12-month period from December 1998 to November 1999, the intensive case management program made 2,449 consumer contacts, with a hospitalization rate of only 1.3 per month.

The emergency service chief executive officer and medical director,

Rocio Nell, M.D., works directly with department staff with inmates with mental illness at the Montgomery County Correctional Facility. Approximately 50 inmates are evaluated each week, and the department provides services for these consumers via the criminal justice, forensic, mobile crisis intervention, and intensive case management programs. The department provides evaluation, follow-up, and referral services to ensure that inmates receive the appropriate services. With funding by a recent grant from the Pennsylvania Commission on Crime and Delinquency, a forensic social worker is housed in the correctional facility to identify, evaluate, and divert severely mentally ill persons from incarceration back to the traditional mental health community.

A multidisciplinary forensic task force works in collaboration with law enforcement and criminal justice agencies, mental health and substance abuse services, the Veterans Administration, the Alliance for the Mentally Ill, and the correctional facility. The task force identifies problems related to persons with mental illness who become involved with the criminal justice system and works to solve them. The task force has helped standardize mental health court order for common pleas court and has helped develop a specialized probation officer to deal directly with mentally ill offenders.

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A Rehabilitation Program for Inpatients in a Large Institution—The Psychosocial Rehabilitation Program at Eastern State Hospital, Williamsburg, Virginia

The psychosocial rehabilitation program at Eastern State Hospital has changed the texture of life for inpatients at the facility and dramatically improved their prospects of returning successfully to the community. Rather than bringing activities to the wards, staff at the hospital have created what they call a treatment mall, housed in two separate buildings, where patients can go to participate in a wide variety of rehabilitation activities.

Eastern State Hospital, the nation's first psychiatric hospital, founded in 1773, is a 500-bed facility on a 550-acre campus located in Williamsburg, Virginia. The hospital serves acute and long-term seriously and persistently mentally ill adults and geriatric patients from the eastern part of the state. Its service area covers 5,000 square miles, encompassing 16 counties with nine community service boards and a population of 1.6 million.

Since the psychosocial rehabilitation program was implemented in March 1997, readmission rates, use of restraints and seclusion, and injuries to staff have all been markedly reduced, and patients' quality of life has been substantially improved by their participation in activities aimed at helping them prepare for the transition back to their communities.

In the traditional, custodial approach to the treatment of persistently and severely mentally ill and geriatric inpatients, patients seldom leave the ward. When activities are offered, they are typically offered on the ward itself, requiring that program staff come to the patients, often to direct a structured group activity, and afterward they move on to the next ward. When activities are not under way on the ward, many patients spend their time watching television or sleeping. Under this model, the number of activities that can be offered on any given ward is limited, and patients have little opportunity to exercise choice or to take any initiative in improving or participating in their own treatment plan.

The key elements of the psychosocial rehabilitation program at Eastern State Hospital are the tailoring of treatment plans to the individual patient, patients' participation as members of their treatment team, and a college-campus model of organizing rehabilitation activities. Along with these elements has come a cultural transformation among patients and staff alike.

Research on the psychiatric rehabilitation approach had already shown that targeted rehabilitation activities can improve levels of functioning among patients with severe and persistent mental illness and improve their ability to manage their symptoms and to cope with living in the community. Under the traditional custodial approach to treatment, however, patients may or may not end up participating in the activities that would improve their level of functioning in the particular areas they might need most.

The staff at Eastern State Hospital wished not only to make use of established principles of psychosocial rehabilitation and to shift away from the custodial model, but to do so using an integrated model that would engage patients and staff in a collaborative, patient-centered treatment program. Building on the successes of other applied methods and programs, they developed and implemented their own model.

Patients at Eastern State Hospital are all encouraged to improve their level of functioning, and all are exposed to rehabilitation activities. Some 200 of the 500 patients participate in the psychosocial rehabilitation program. Patients and staff work out detailed individualized treatment plans using a centralized and interdisciplinary approach incorporating ancillary and support services. A computer program developed specifically for the complex task of communicating patient assignments and group participation to staff and treatment teams was praised during a recent survey by the Joint Commission on Accreditation of Healthcare Organizations.

Patients select activities from a varied list of some 300 offerings and arrange their schedules as they would a college course schedule. Many activities are designed to work

directly on improving or coping with aspects of mental illness. For example, groups are offered for developing interpersonal and social skills, acquiring coping skills, managing symptoms, and managing medication. A reality orientation group is offered, and a polydipsia group is available to help patients cope with that specific symptom. Groups are available specifically on personal care. Other, more general activities related to mental health include groups on boosting self-esteem, improving self-awareness, dealing with depression, managing stress and anger, and the like.

Another major category of activities addresses patients' physical well-being. Groups on nutrition, health education, and substance use are offered, and patients can choose from a large number of exercise and sports activities—basketball, weightlifting, swimming, walking, Frisbee, volleyball, and so on.

Also notable among the offerings are activities related specifically to patients' reintegration into the community, including work and volunteer opportunities. Developing roles as workers and contributors is important for patients' self-esteem and sense of hope and belonging, and earning their own spending money is additionally satisfying. Patients can attend groups on money management, independent living skills, life skills, job interviewing, and even community awareness. They have opportunities to be members of the clubhouse on campus as well as to take trips back to their own community clubhouses in order to stay connected. Although activities in this category are overtly geared to preparing patients to return to their communities, all of the available activities play a role in fulfilling this goal.

Activities are scheduled throughout the week, and patients from all wards can attend groups that are part of their treatment plan or that merely interest them. Thus patients leave the ward to participate in activities and return later—just as persons living in the community leave their homes to participate in various social and vocational activities and return later.

The therapeutic value of leaving the ward is itself notable, fostering autonomy, initiative, and responsibility among patients. Patient identification badges allow staff to determine patients' privilege levels at a glance, thus allowing patients greater independence and reducing the need for direct staff monitoring. Equally important is that patients can spend the entire "work day" engaging in a wide variety of activities designed to improve their level of functioning. The ability to devote an adequate amount of time to rehabilitation and to minimize down time or idle time enhances their prospects of returning successfully to the community. Discharged patients leave with skills and expectations that enable them both to function better and to advocate for themselves.

Implementing the model did not require a change in the number of staff, but staff roles and functions changed dramatically. Staff members fulfill the traditional duties expected of team members but also have assumed additional roles as group facilitators and coaches to the clients they serve. Patients, for their part, are now members of their treatment team and take a more active role, as informed consumers, in their treatment. Staff and visitors alike have remarked on patients' focus as they move from task to task and their ability to describe what they are doing and what they hope to accomplish.

Although state hospitals are not typically known for their provision of dynamic and active treatment and rehabilitation, this program not only has demonstrated that this approach is possible but also has served as a model for other facilities in the state.

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Psychiatric Services to Focus on Depression Treatment in 2001

Next year *Psychiatric Services* will publish a series of articles on the treatment of depression. The editor of the series, Charles L. Bowden, M.D., of the University of Texas Health Science Center in San Antonio, invites contributions that address major depression, bipolar depression, dysthymia, and dysphoric mania. Papers should focus on integrating new information for the purpose of improving some aspect of diagnosis or treatment of one or more of these conditions.

Please contact Dr. Bowden for more information about appropriate topic areas and submission of papers.

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