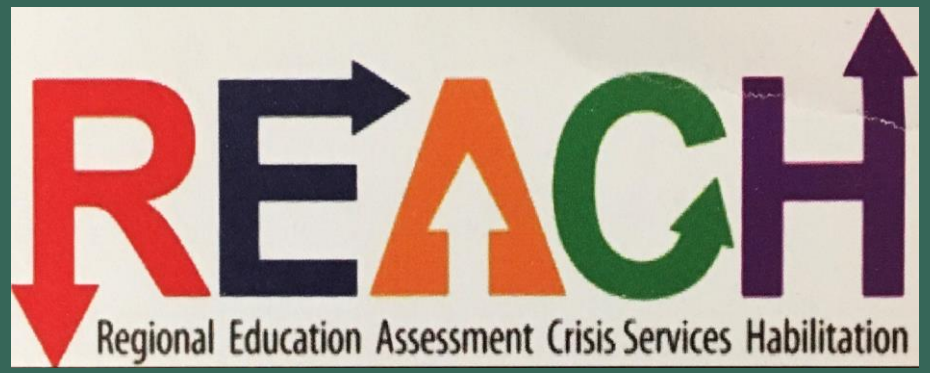
ASSESSMENT AND TREATMENT OF PSYCHIATRIC CONDITIONS

PRESENTED BY: V. J. PETILLO, MS/PBSF – REGION 4 REACH SYSTEMS TRAINER

VICTOR.PETILLO@RBHA.ORG / 804-380-2636



DEFINITION: MENTAL ILLNESS

- *Mental illness* is a condition that impacts a person's thinking, feeling or mood and may affect and his or her ability to relate to others and function on a daily basis.
- Affects an estimated 1 in 5 adults in the general population (NAMI); as high as 1 in 3 individuals with IDD.
- Diagnosed by a licensed mental health professional (ex. psychiatrist, psychologist, LCSW, LPC); general practitioners/MDs can also diagnose MH conditions

COMPARISON BETWEEN I/DD AND MI

Intellectual/Developmental Disability	Mental Illness
• **Below-average ability to learn and to use information**	• Inappropriate thought processes and/or emotions
• **Before adulthood**	• Can occur anytime in a person's life
• **Refers to sub-average functional intellect**	• Has nothing to do with intellect
• **Lifelong**	• May be temporary, cyclic, or episodic
• **Services involve education, daily living supports, and training**	• Services involve therapy and medication
• **Is not psychiatric in nature**	• Diagnosed illnesses such as Depression, Schizophrenia, Bi-Polar Disorder
• **Impairments in social skills**	• Does not necessarily impact social competence
• **Behavior is usually rational**	• Behavior may vacillate between normal and irrational

FLETCHER, ET. AL. 2015

BRIEF HISTORY OF IDD AND MENTAL HEALTH

- Prior to the 1980s, it was assumed that people with intellectual disabilities could not also have a mental illness, and behavioral challenges were seen as a consequence of cognitive limitations (i.e., the diagnosis of ID).
- Restraints, medication, behavior "management" (including punishment) were used to control behavior; medications were primarily a means to restrain behavior, rather than treat a mental health condition.

National Core Indicators™ Data Brief, 2019

BRIEF HISTORY OF IDD AND MENTAL HEALTH

- There was a time when low IQ = mental illness in and of itself AND it was thought that it protected an individual from more "intellectual" psychiatric illnesses
- 1960's and 70's: more evidence that people with ID can have co-occurring mental illness
- Increased interest and assessment over the past 30-40 years has led to increased diagnosis and improved services (became "dual diagnosis")
- Behavioral assessment once ignored psychiatric, medical, and social conditions but now wholly incorporates them ("Biopsychosocial")
- Organizations formed (NADD)

DIAGNOSTIC ISSUES

Many factors affected and can continue to affect the ability to make accurate diagnoses :

- Reliance on individual's ability to express thoughts and emotions
- Difficulties with expressive skills
- People with ID may "hide" their disability and therefore hold back or provide inaccurate information
- MH conditions may be expressed differently in persons with ID
- ***Diagnostic overshadowing:*** clinician may be predisposed to overlook psychopathology due to ID

DIAGNOSTIC ISSUES

Diagnostic Overshadowing: to over-attribute symptoms of mental illness to ID; only able to see the cognitive disability and, subsequently, attribute all symptoms and problems to it

- Severe behavioral disturbances are not simply a typical characteristic of ID
- IQ cannot be a reason for or cause of mental health conditions or behavioral problems; however, it can be a complicating factor

STATISTICS

NCI In-Person Survey data that was collected in 2017-18 by 35 states regarding the prevalence of the following diagnoses for persons with IDD:

- Mood disorder
- Anxiety disorder
- Psychotic disorder
- Other mental health diagnosis

Of the 22,513 survey respondents, 10,729 (approximately 48%) met the criteria for one or more of these diagnoses; this is compared to 15% - 19% prevalence of mental illness within the general population

National Core Indicators™ Data Brief, 2019

STATISTICS

Total U.S. Population:
308,745,538
(U.S. Census Bureau, Census 2010)

Number of People In Total Population With IDD:
5,156,050
(1.67% - Schalock et al., 2010)

Number of People With IDD Who Have MI:
1,701,496
(33% of ID – Hobden & LeRoy, 2009)

Possible Factors for Mental Disorders

Whole population	People with intellectual disabilities
• **Family history/genetic vulnerability** • **Neurological disorders** • **Other physical disorders** • **Alcohol and illicit drug use** • **Side-effects of prescribed medication**	• Behavioral phenotypes (psychiatric sequelae of underlying genetic disorders) • Psychiatric sequelae of other neurological/metabolic/infective causes of intellectual disabilities • Epilepsy • Other physical sequelae of genetic disorders, e.g. hypothyroidism associated with Down's syndrome • Sensory impairments • Multiple physical disabilities and illness • Multiple prescribed medications and drug interactions

Biological Factors

Understanding Intellectual Disability and Health (www.intellectualdisability.info)

Possible Factors for Mental Disorders

Whole population	People with intellectual disabilities
• **Adverse experiences in early life affecting development of personality, confidence, self-esteem, coping strategies** • **Traumatic experiences at any stage of life**	• Identification of learning experiences affecting parent-infant bonding and family dynamics • Childhood spent outside a family home, e.g. hospital, residential school, children's home • Lack of consistent parenting and special one-to-one relationship • Repeated broken relationships, e.g. hospital care, multiple moves between foster homes • childhood and adult exploitation, neglect, abuse • Bullying, harassment • Experiences resulting in long-term difficulties establishing trusting confiding relationship, low self-esteem, low confidence, limited coping strategies

Psychological Factors

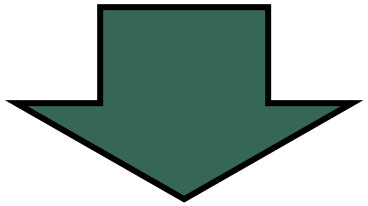
Possible Factors for Mental Disorders

Whole population	People with intellectual disabilities
• **Life events** • **Poverty** • **Unemployment** • **Limited social networks** • **Social exclusion**	• Life events are often multiple: e.g. death of mother often results in a change in residence + change in day center + move from familiar neighborhood + loss of previous social network + sharing a home with new people • Low income (benefits) • Limited choices and opportunities • Poverty of environment • Problems accessing transport • Limited social networks • Limited one-to-one attention • Repeated pattern of broken relationships • Exploitation and abuse • Stigma • Social exclusion

Social Factors

PREVALENCE

In summary, a higher prevalence of mental illness among people with intellectual disabilities is explained in ***biopsychosocial terms***



*Therefore, a ***biopsychosocial approach*** is *essential* in assessment and treatment of mental illness in persons with I/DD

IMPLICATIONS

What does this all mean for us?

- Collaboration across systems and disciplines (Multidisciplinary approach)…including mental health professionals
- Assessment needs to be biopsychosocial; create a Multi-disciplinary Team (MDT) as the clinical "hub" for your organization
- Improved behavioral and mental health assessment, planning, and implementation
- Continuous learning and cross-training
- Person-centered thinking and planning

DEFINITION

Psychotropic Medication: drugs prescribed to stabilize or improve mood, thoughts, and behavior.

FOUR MAJOR CLASSES OF PSYCHOTROPIC MEDICATIONS

- Antidepressants
- Antianxiety
- Antipsychotics
- Mood Stabilizers

DEPRESSION

DSM 5 Symptom for Depression	Presentation in Someone with IDD
DSM-5: Change in terminology to Major Depressive Disorder	•Frequent unexplained crying •Decrease in laughter and smiling •General irritability and subsequent aggression or self-injury •Sad facial expression
Markedly diminished interest or pleasure in all, or almost all, activities most of the day nearly every day	•No longer participates in favorite activities •Reinforcers no longer valued •Increased time spent alone •Refusals of most work/social activities

HUGHES, 2006

DEPRESSION

DSM 5 Symptom for Depression	Presentation in Someone with IDD
Weight Change/ Appetite Change	•Measured weight changes •Increased refusals to come to table to eat •Unusually disruptive at meal times •Constant food seeking behaviors
Insomnia	•Disruptive at bed time •Repeatedly gets up at night •Difficulty falling asleep •No longer gets up for work/activities •Early morning awakening
Hypersomnia	•Over 12 hours of sleep per day •Naps frequently

HUGHES, 2006

DEPRESSION

DSM 5 Symptom for Depression	Presentation in Someone with IDD
Psychomotor Agitation	• Restless, Fidgety, Pacing • Increased disruptive behavior
Psychomotor Retardation	• Sits for extended periods • Moves slowly • Takes longer than usual to complete activities

HUGHES, 2006

DEPRESSION

DSM 5 Symptom for Depression	Presentation in Someone with IDD
Fatigue/Loss of Energy	•Needs frequent breaks to complete simple activity •Slumped/tired body posture •Does not complete tasks with multiple steps
Inappropriate guilt	•Statements like "I'm dumb," "I'm retarded," etc. •Seeming to seek punishment •Social isolation

HUGHES, 2006

DEPRESSION

DSM 5 Symptom for Depression	Presentation in Someone with IDD
Lack of Concentration/ Diminished Ability to Think/Indecisiveness	•Decreased work output •Does not stay with tasks •Decrease in IQ upon retesting
Thoughts of Death	•Preoccupation with family member's death •Talking about committing or attempting suicide •Fascination with violent movies/television shows

HUGHES, 2006

ANTIDEPRESSANT MEDICATION

Treat:

- Depression
- Post-traumatic Stress Disorder
- Obsessive-compulsive Disorder
- Other chronic anxiety

- Restore balance of certain chemicals in the brain (serotonin)
- Can bring relief in 4 – 6 weeks
- SSRI examples – fluoxetine, paroxetine, sertraline, fluvoxamine, citalopram
- Tricyclic examples – amitriptyline, imipramine, desipramine

BIPOLAR DISORDER

DSM 5 Symptoms of Mania	Presentation in Someone with IDD
Elevated, expansive, or irritable mood and abnormally and persistently increasing goal-directed activity or energy	• Smiling, hugging or being affectionate with people who previously were not favored by the individual • Boisterousness • Over-reactivity to small incidents • Extreme excitement • Excessive laughing and giggling • Self-injury associated with irritability • Enthusiastic greeting of everyone

HUGHES, 2006

BIPOLAR DISORDER

DSM 5 Symptoms of Mania	Presentation in Someone with IDD
Increased energy or activity and 3 or more of the following: **Inflated self-esteem/grandiosity** **Decreased need for sleep** **More talkative/pressured speech** **Flight of ideas** **Distractibility** **Increase in psychomotor agitation** **Excessive involvement in activities that have a high potential for painful consequences**	• **Behavioral challenges when prompted to go to try to sleep** • **Constantly getting up at night** • **Seems rested after not sleeping (i.e., not irritable due to lack of sleep as is common in depression)**

HUGHES, 2006

BIPOLAR DISORDER

DSM 5 Symptoms of Mania	Presentation in Someone with IDD
Inflated Self-esteem/ Grandiosity	• Making improbable claims (e.g., is a staff member, has mastered all necessary skills, etc.) • Dramatic physical presentation • Dressing provocatively • Demanding rewards
Flight of Ideas	• Disorganized speech • Thoughts not connected • Quickly changing subjects

HUGHES, 2006

BIPOLAR DISORDER

DSM 5 Symptoms of Mania	Presentation in Someone with IDD
More Talkative/ Pressured Speech	• Increased singing • Increased swearing • Perseverative speech • Screaming • Frequent interrupting • Non-verbal communication increases • Increase in vocalizations

HUGHES, 2006

BIPOLAR DISORDER

DSM 5 Symptoms of Mania	Presentation in Someone with IDD
Distractibility	• Decrease in work/task performance • Leaving tasks incomplete • Inability to settle (e.g., stay seated and focus on favorite TV show, stay seated through a complete activity when generally able to do so)

HUGHES, 2006

BIPOLAR DISORDER

DSM 5 Symptoms of Mania	Presentation in Someone with IDD
Agitation/Increase in Goal Directed Behavior	• Pacing • Negativism • Working on many activities at once • Fidgeting • Aggression • Rarely sits
Excessive Pleasurable Activities	• Increase in masturbation • Giving away/spending money

HUGHES, 2006

MOOD STABILIZERS

- Treat disorders characterized by rapid and unstable mood shifts
- Bipolar Disorder
- Borderline Personality Disorder

- Some mood stabilizers were originally developed to treat seizure disorders (anticonvulsants) – divalproex, carbamazepine, lamotrigine, oxcarbazepine, topirimate, and gabapentin
- Lithium is also widely used (not an anticonvulsant)
- May be used with an antidepressant to treat depression

ANXIETY DISORDERS

DSM 5 Symptoms of Generalized Anxiety Disorder	Presentation in Someone with IDD
A. **Developmentally inappropriate and excessive fear or anxiety** **Anxiety or worry associated with 3 or more of the following 6:** • **Restlessness** • **Easily fatigued** • **Difficulty concentrating** • **Irritability** • **Muscle tension** • **Sleep disturbances**	• **No adaptation from criteria in DSM 5**

DM-ID, 2007

ANXIETY DISORDERS

DSM 5 Symptoms of Generalized Anxiety Disorder	Presentation in Someone with IDD
B. Fear, anxiety or avoidance is persistent, lasting at least 4 wks	• **Inapplicable in persons with Profound IDD (may mean it's diagnosis is not possible based on the person's limited ability for insight about thoughts or articulate thoughts and feelings).**
C. Focus of Anxiety or worry	• **No adaptation from DSM 5 for mild to moderate IDD. Difficulty to apply in persons with severe IDD. Inapplicable in persons with profound IDD.**

ANXIETY DISORDERS

DSM 5 Symptoms of Generalized Anxiety Disorder	Presentation in Someone with IDD
E. Anxiety or worry causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.	• No adaptation from DSM 5
F. Anxiety or worry is not connected to the physiological effects of a substance, e.g., medication, drug or medical condition or not better explained by another disorder	• No adaptation from DSM 5

ANTIANXIETY MEDICATION (ACUTE ONSET)

- Relieve acute (sudden onset) anxiety
- Can treat anxiety caused by illness

- Can help ease physiological symptoms of anxiety, such as rapid heart beat, irregular breathing, tremors, stomach aches, and difficulty sleeping
- Work quickly
- Caution: tolerance and dependence may develop (habit-forming and, therefore, addictive)
- Examples: lorazepam, clonazepam, diazepam, alprazolam

ANTIANXIETY MEDICATION (CHRONIC)

Treatment of:

- Obsessive-compulsive Disorder
- Other chronic anxiety

- Restore balance of certain chemicals in the brain (serotonin)
- Can bring relief in 4 – 6 weeks
- SSRI examples – fluoxetine, paroxetine, sertraline, fluvoxamine, citalopram

PSYCHOSIS

DSM 5 Symptoms Of Schizophrenia	Presentation in Someone with IDD
A) Two or more of the following present for a significant portion of a 1 month period: • **Delusions** • **Hallucinations** • **Disorganized speech** • **Grossly disorganized behavior** • **Negative symptoms, i.e., affect flattening, newly evidenced inability to speak, general lack of motivation or desire to pursue meaningful goals.**	• **No adaptation – note that developmentally appropriate self-talk, imaginary friends, fantasy play, and beliefs based on faulty learning can be confused with hallucinations and delusions.**

PSYCHOSIS

DSM 5 Symptoms of Schizophrenia	Presentation in Someone with IDD
B. Level of functioning in one or more major areas, such as work, interpersonal relations, or self-care is markedly below the level achieved prior to onset	• No Adaptation – but note that functional areas are dependent upon functioning level for the person.
C. Duration – continuous signs of the disturbance exist for at least six months.	• No adaptation from DSM 5 level of skill markedly below level achieved prior to onset for example, self-care skills, interpersonal relations,

Psychosis

DSM IV-TR Symptoms of Schizophrenia	Presentation in Someone with ID
D) Schizoaffective disorder and depressive bipolar disorder with psychotic features have been ruled out	• No adaptation from DSM-5
E) The disturbance is not due to direct physiological effects of substance or general medical condition	• No adaptation from DSM-5

DM-ID, 2007

ANTIPSYCHOTIC MEDICATION

- Treat Schizophrenia and other psychotic disorders
- May also be useful in treating mood disorders
- Have also been used to treat "behavior" and ASD

- Restore balance of certain chemicals in the brain (dopamine, serotonin, others)
- "Traditional" (first generation) antipsychotics – haloperidol, chlorpromazine, thioridazine, and thiothixene
- "Atypical" (newer) antipsychotics – risperidone, quetiapine, olanzapine, ziprasidone, and clozapine. May be helpful for those for whom traditional meds are effective AND have fewer serious side effects

PRN MEDICATION

- Know the purpose of the PRN medication
- Ask the psychiatrist to be specific about it's intended use (for example:"…for agitation" might not be specific enough)
- Consider developing a "PRN Protocol" for when and how to administer it
- Track the use and effectiveness of the PRN

SIDE EFFECTS

- All psychotropic medications have potential side effects, some more significant than others
- Monitor for intended and unintended effects and report problems to the prescribing physician

IMPLICATIONS FOR PROVIDERS/SUPPORTERS

- Be educated about medications (uses and side effects) We must assure that we each do our part to assure that medications are being used appropriately
- Should be monitored by a treatment and/or multidisciplinary team (MDT)
- Monitor side effects on a regular basis
- Integrate psychiatric treatment with behavioral, person-centered, medical, and habilitative services and supports
- Minimize the use of PRN medication
- Maintain good data

CONSULTING WITH PSYCHIATRISTS

- Bring data (don't just tell stories)
- Prepare ahead of time
- Ask questions
- Psychiatric Consultation Form

REFERENCES

NADD: www.thenadd.org

Diagnostic Manual: Intellectual Disability – Second Edition (DM-ID 2)

Mental Health Approaches to Intellectual/Developmental Disability: A Resource for Trainers, 2nd Edition (NADD)

The Dual Diagnosis Primer

QUESTIONS???


REACH
Regional Education Assessment Crisis Services Habilitation