Project funded by a grant from the Mental Health Services Act in partnership with the CA Dept. of Developmental Services and Dept. of Mental Health

Assessment & Communication: Working with Individuals with an Intellectual Disability and Mental Illness

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Sponsored by the North Bay Regional Center, NADD, and funded by a grant from the Mental Health Services Act in partnership with the CA Dept. of Developmental Services and Dept. of Mental Health

Outline of Presentation

- Concept of Dual Diagnosis
- Vulnerability Factors
- Models of Problem Behavior
- Assessment & Diagnostic Procedures
- Diagnostic Procedures
  - Depression
  - Bi-Polar
- Overview of the DM-ID
- Supportive Strategies

WHAT IS NATIONAL ASSOCIATION FOR THE DUALLY DIAGNOSED?

NADD

- NADD is a not-for-profit membership association
- Established for professionals, care providers and families
- To promote the understanding of and services for individuals who have developmental disabilities and mental health needs

MISSION STATEMENT

To advance mental wellness for persons with developmental disabilities through the promotion of excellence in mental health care.

- *NADD Bulletin*
- *Conferences/Trainings*
- *Research Journal*
- *Training & Educational Products*
- *Consultation Services*
- *Accreditation and Certification Program*

CONCEPT OF DUAL DIAGNOSIS

Concept Of Dual Diagnosis

- **Co-Existence of Two Disabilities:**
  Intellectual Disability and
  Mental Illness
- **Both Intellectual Disability and Mental Health disorders should be assessed and diagnosed**
- **All needed treatments and supports should be available, effective and accessible**

Terminology

Intellectual Disability
Mental Retardation
Developmental Disability
Intellectual Impairment
Learning Disability (UK)

Dual Diagnosis
Dual Disability
Co-Occurring MI-ID
Co-Existing Disorders

Fletcher, 2008

Diagnostic Criteria Of Intellectual Disability

A. Significant sub-average intellectual functioning

    1. IQ of 70 or below

B. Concurrent deficits in adaptive functioning

C. Onset before age 18 years

Deficits in Adaptive Functioning

- **Self-care**
- **Language and communication**
- **Community use**
- **Independent living skills**

Deficits in Adaptive Functioning
(continued)

- Socialization skills
- Health and safety
- Work
- Self-direction

DM-ID, 2007

Four Levels of ID

Level	IQ Range	%
Mild ID	55-70	85
Moderate ID	35-55	10
Severe ID	20-35	3
Profound ID	below 20	2

MENTAL HEALTH PROBLEMS vs. MENTAL ILLNESS

People occasionally experience mental health problems that may:

- **Change the way they think and understand the world around them**
- **Change the way they interrelate with others**
- **Change the emotions and feelings they have**

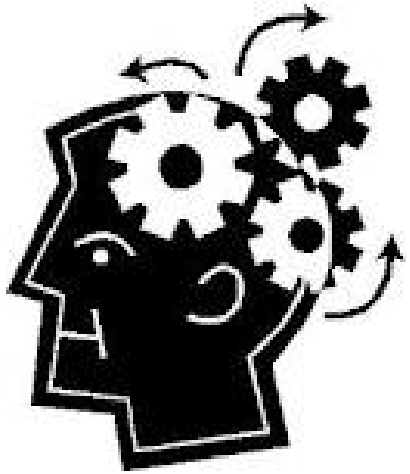
These changes can have a short-term impact on the way they deal with day-to-day life

However, if the impact is very great (ongoing problems with repeated relapse episodes) then we talk about mental illness

Fletcher, 2011

What Is Mental Illness (MI)?

- MI is a medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others, and daily functioning.
- MI can affect persons of any age, race, religion, income, or level of intelligence.
- The DSM-IV-TR or the DM-ID provide a classification system of diagnoses.



What Is Mental Illness? (cont)

- Mental illness is a biological process which affects the brain. Some refer to it as a brain disorder.

Definition Of Mental Illness In Persons With Intellectual Disability

1. When behavior is abnormal by virtue of quantitative or qualitative differences

2. When behavior cannot be explained on the basis of development delay alone

3. When behavior causes significant impairment in functioning

Adapted from Enfield and Aman 1995

A Summary Of Similarities And Differences Between Intellectual Disability (ID) & Mental Illness (MI)

ID: refers to sub-average (IQ)

MI: has nothing to do with IQ

ID: incidence: 1-2% of general population

MI: incidence: 16-20% of general population

ID: present at birth or occurs before age 18

MI: may have its onset at any age (usually late adolescent)

Fletcher, 2004

A Summary Of Similarities And Differences Between Intellectual Disability (ID) & Mental Illness (MI)

ID: intellectual impairment is permanent

MI: often temporary and may be reversible and is often cyclic

ID: a person can usually be expected to behave rationally at his or her developmental level

MI: a person may vacillate between normal and irrational behavior, displaying degrees of each

ID: adjustment difficulties are secondary to ID

MI: adjustment difficulties are secondary to psychopathology

Fletcher, 2004

Prevalence of MI in ID

Two to Four Times
as typical population
(Corbett 1979)

1/3 of People with ID have co-occurring MI (NADD, 2005)

Fletcher, 2005

Prevalence

Total U.S. Population:

308,745,538

(U.S. Census Bureau, Census 2010)

Number of People In Total Population With ID:

5,156,050

(1.67% - AAIDD, 2010)

Number of People With ID Who Have MI:

1,701,496

(33% of ID – NADD, 2008)

Prevalence

Total Montana Population:

989,415

(U.S. Census Bureau 2010)

Number of People in Total Population With ID:

16,523

(1.67% - AAIDD 2010)

Number of People With ID Who Have MI:

5,452

(33% of ID – NADD 2008)

Characteristics Of Persons With ID/MI

- High Vulnerability to Stress
  - The impact of a minimally stressful situation can be experienced as significant.

McCleese, 2010

Characteristics Of Persons With ID/MI

- Challenges with Coping Skills
  - Frequently lack the basic skills required for everyday living; e.g., budgeting money, using public transportation, doing laundry, preparing meals, etc.

Characteristics Of Persons With ID/MI

- **Difficulty Working in the Competitive Job Market**
  - **People with ID/MI often have difficulty working in a competitive employment. They may have frequent job changes interspersed with long periods of unemployment**

Fletcher, 2011

Characteristics of Persons with ID/MH

Employment (community job)

	Hours worked in 2 weeks	Amount earned in two weeks	Hourly Wage	Earning at or above minimum wage (%)	Length at current job
Dual Diagnosis	30.6	$170	$5.81	35%	56 months
ID Only	31.5	$201	$6.40	43%	66 months

NCI Survey Report, 2010

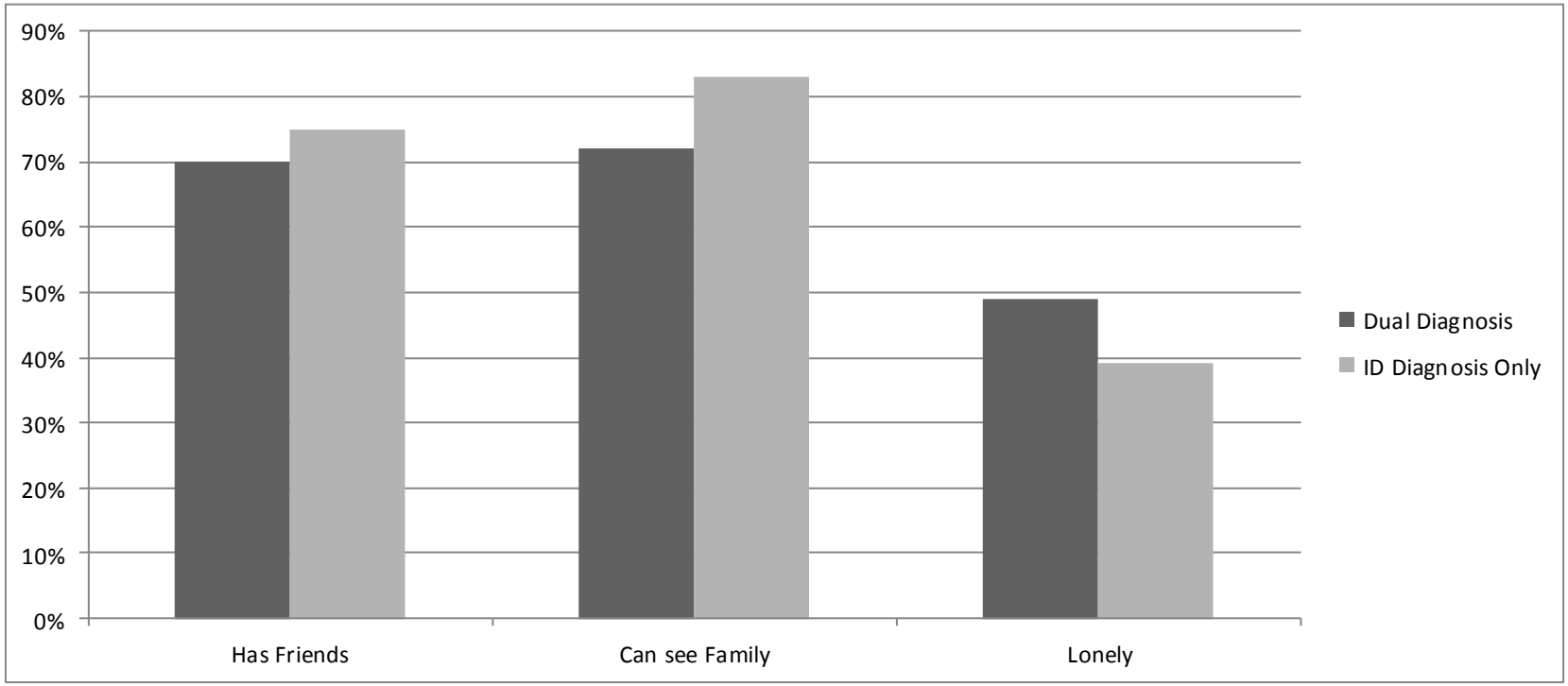
Characteristics Of Persons With ID/MI

- **Difficulty with Interpersonal Relationships**
  - **Individuals with ID/MH typically have difficulty with interpersonal relationships**
  - **These interpersonal relationship problems can result in disruption in school, home, work, and social environments**

Fletcher, 2011

Characteristics Of Persons With ID/MH

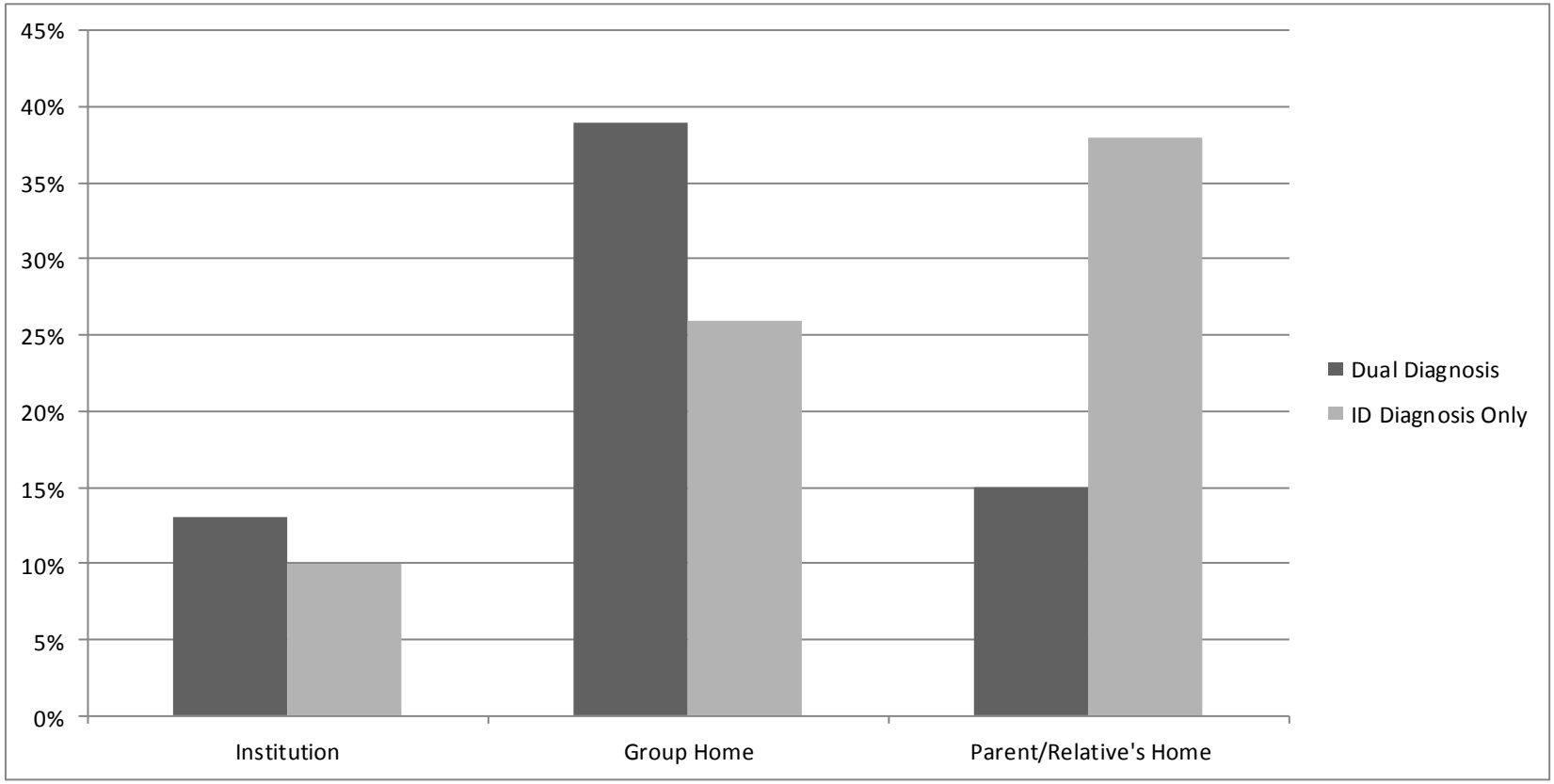
Relationships



NCI Survey Report, 2010

Characteristics of Persons with ID/MH

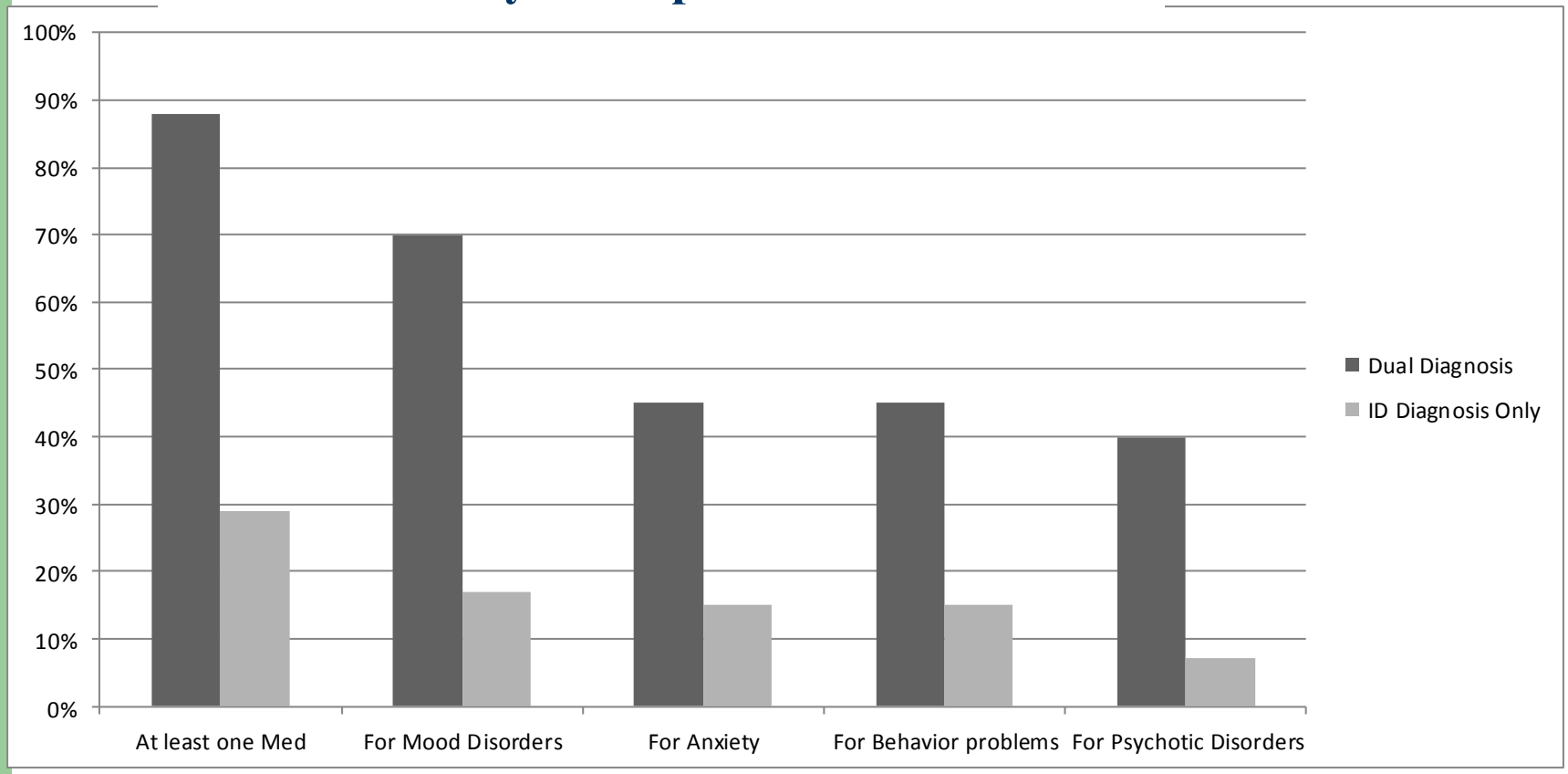
Type of Residence



NCI Survey Report, 2010

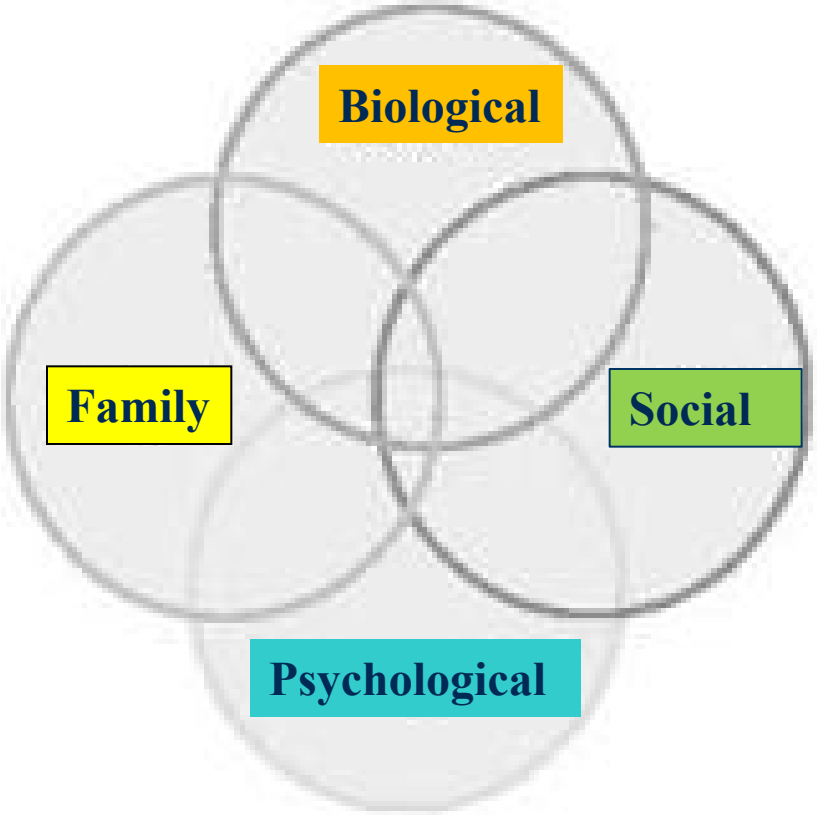
Characteristics of Persons with ID/MH

Use of Psychotropic Medications



NCI Survey Report, 2010

VULNERABILITY FACTORS FOR DEVELOPING PSYCHIATRIC DISORDERS IN PERSONS WITH ID



Vulnerability Factors

Persons with ID are at increased risk of developing psychiatric disorders due to complex interaction of multiple factors:

- **Biological**
- **Psychological**
- **Social**
- **Family**

Royal College of Psychiatrists, 2001

Vulnerability Factors

Vulnerability factors for psychiatric disorders

Biological

- Brain damage/epilepsy
- Vision/hearing impairments
- Physical illnesses/disabilities
- Genetic/familial conditions
- Drugs/alcohol abuse
- Medication/physical treatments

Royal College of Psychiatrists, 2001

Vulnerability Factors

Vulnerability factors for psychiatric disorders

Psychological

- Rejection/deprivation/abuse
- Life events/separations/losses
- Poor problem-solving/coping strategies
- Social/emotional/sexual vulnerabilities
- Poor self-acceptance/low self-esteem
- Devaluation/disempowerment

Royal College of Psychiatrists, 2001

Vulnerability Factors

Vulnerability factors for psychiatric disorders

Social

- Negative attitudes/expectations
- Stigmatization/prejudice/social exclusion
- Poor supports/relationships/networks
- Inappropriate environments/services
- Financial/legal disadvantages

Royal College of Psychiatrists, 2001

Vulnerability Factors

Vulnerability factors for psychiatric disorders

Family

- Diagnostic/bereavement issues
- Life-cycle transitions/crises
- Stress/adaptation to disability
- Limited social/community networks
- Difficulties “letting go”

Royal College of Psychiatrists, 2001

CONCEPTUAL MODELS RELATED TO BEHAVIORAL PROBLEMS :

AN INTEGRATED ASSESSMENT APPROACH

Conceptual Models Related to Behavioral Problems

I. Five Conceptual Models:

1. Medical Model
2. Communication Model
3. Behavioral Model
4. Psychiatric Model
5. Integrative Model (1-4)

Fletcher, 2012

Conceptual Models Related to Behavioral Problems

1. **Medical Model**
   - **Problem behaviors are exhibited because of co-existing medical problems**
   - **Assessment of potential medical problems involves conducting a full medical work-up**
   - **Treatment focuses on addressing the underlying medical problem**

Conceptual Models Related to Behavioral Problems

2. Communication Model

- Views behavioral problems as reflecting "challenging behaviors" in persons who have deficits in language skills

- Behavioral problems due to communication deficits

Fletcher, 2012

Conceptual Models Related to Behavioral Problems

2. Communication Model (continued)

- Assessment focuses on evaluation of skills, deficits and assets and elicits the communicative intent of the behaviors
- Treatment - teach communication skills

Conceptual Models Related to Behavioral Problems

3. Behavioral Model

- Problem behaviors are viewed according to learning principles
- Assessment elicits the antecedent and consequences of the problematic behavior
- Treatment focuses on change in behavior though behavioral approaches, i.e., Positive Behavioral Supports

Fletcher, 2012

Conceptual Models Related to Behavioral Problems

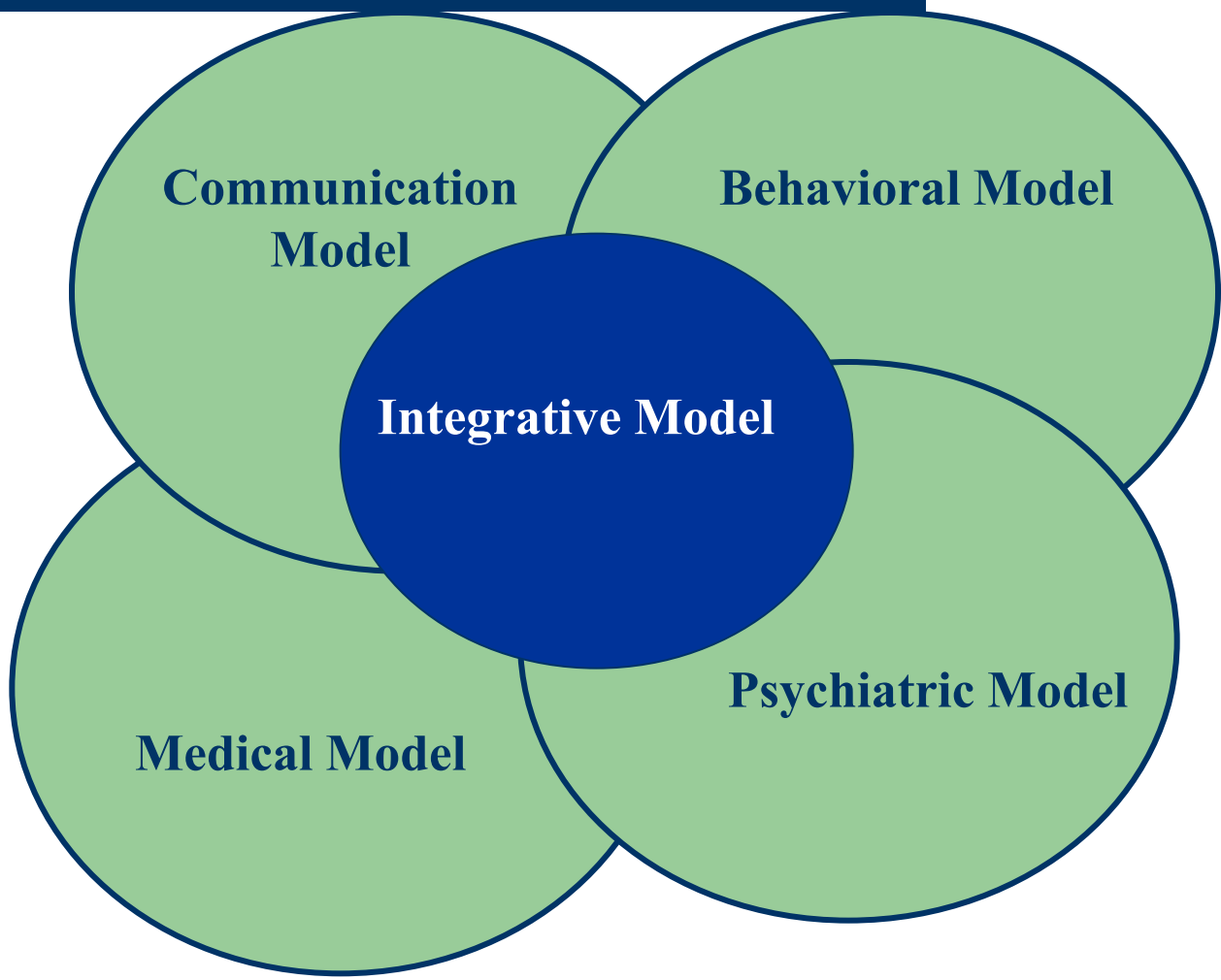
4. Psychiatric Model

- Views problem behavior as a possible manifestation of a mental disorder
- Presentation of problem behaviors may be associated with a psychiatric disorder
- Assessment based on a bio-psycho-social model
- Treatment focuses on underlying psychiatric disorders

Fletcher, 2012

Conceptual Models Related to Behavioral Problems

5. Integrative Model



Fletcher, 2012

Conceptual Models Related to Behavioral Problems

Case Vignette: John

- 15-year old male, IQ = 50
- Living with parents
- Becoming angry/hostile at school with other students
- Recent onset of behavioral problems
  - SIB
  - Property Destruction
- Sleep disturbance
- Displays agitation and aggression
- Limited verbal communication skills
- Appetite decreased
- Constipation
- No previous psychiatric history

Fletcher, 2009

The Relationship of Challenging Behavior and Intellectual Disability

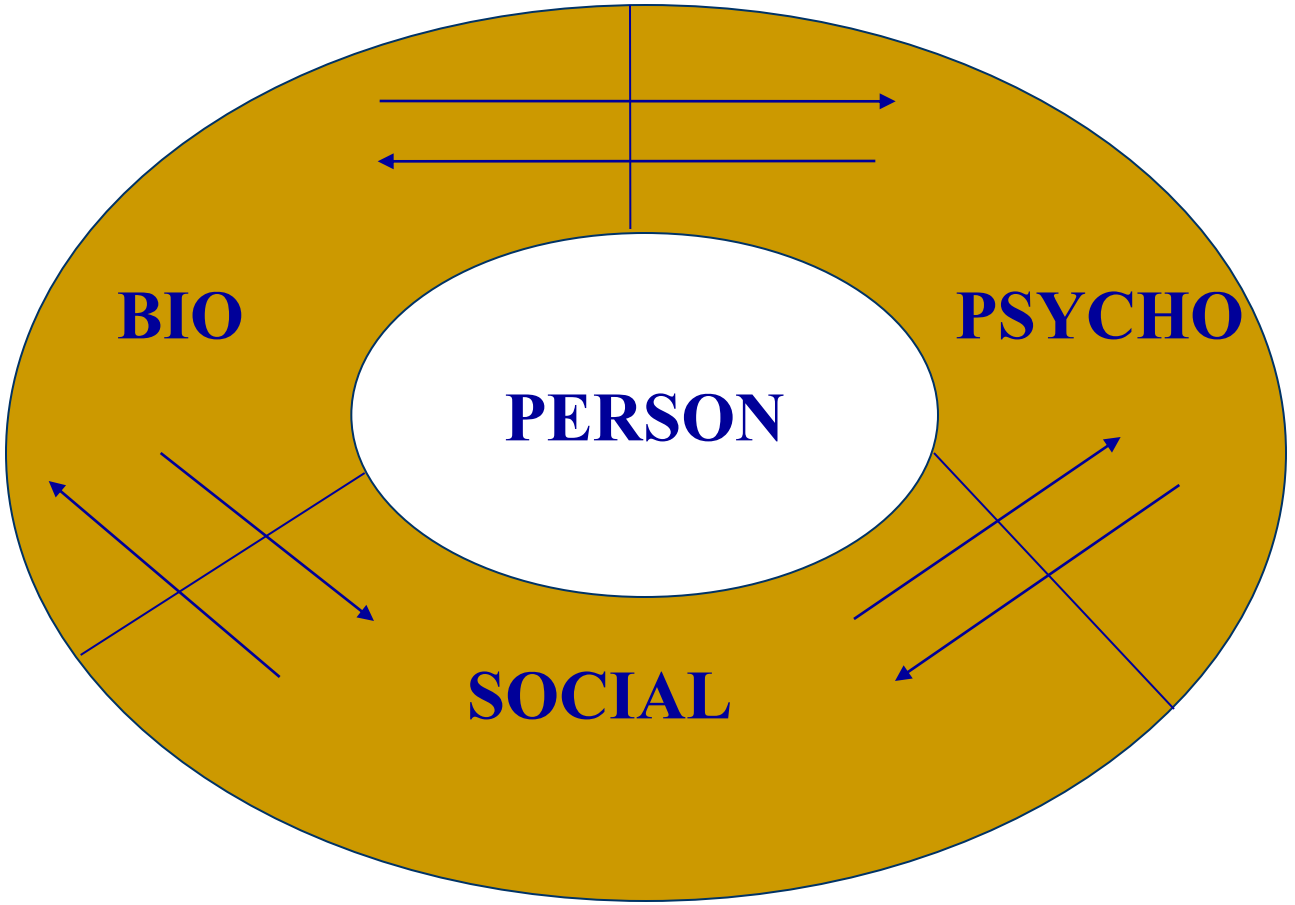
Type of Model	Medical	Communication	Behavioral	Psychiatric
Assessment	Medical Evaluation by primary care physician	Standardized administered measure of expressive language	Functional Analysis	DM-ID
Problem Identification	Constipation	Speech and language impairment	Occurrence of problem behavior	Affective disorder, mania
Treatment	Medication for Bowel Movement (Laxative)	Functional communication skill training	Positive behavior support	Medication treatment, psychotherapy

BEST PRACTICES

IN

ASSESSMENT AND DIAGNOSTIC PROCEDURES

Best Practice Assessment: Bio-psychosocial Model



Fletcher - 2005

Best Practice Assessment: Bio-psychosocial Model

1. Review Reports
2. Interview Family
3. Interview Care Provider
4. Direct Observation
5. Clinical Interview

Mental Health Assessment

I. Source of Information and Reason for Referral

II. History of Presenting Problem and Past Psychiatric History

III. Family Health History

IV. Social and Developmental History

Fletcher, 2009

Mental Health Assessment

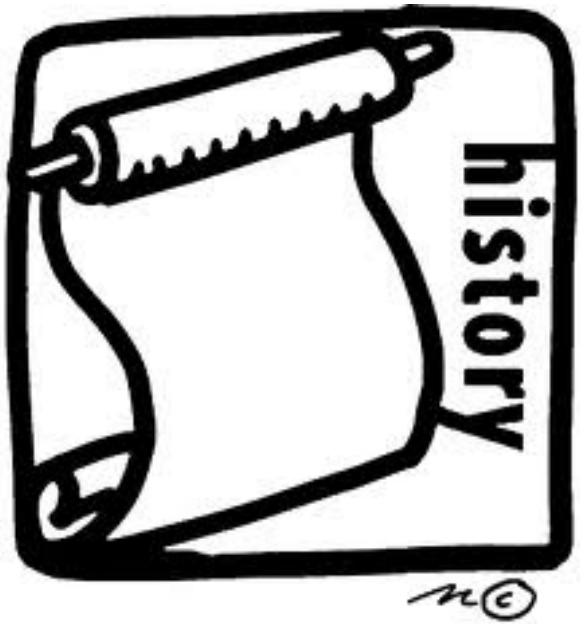
I. Source of Information and Reason for Referral

- Who made the referral?
- What is different from baseline behavior?
- Why make the referral now?

Fletcher, 2009

Mental Health Assessment

II. History of Presenting Problem and Past Psychiatric History



- How long has the problem occurred?
- History of mental health treatment

Fletcher, 2009

Mental Health Assessment

III. Personal and Family Health History

- Medical, psychiatric, and substance abuse history
- Psychotropic medications
- Medical conditions
  - Genetic disorders
  - Hypo/hyper thyroid condition
  - Constipation
  - Epilepsy
  - Diabetes
  - Gastrointestinal problem

Fletcher, 2009

Mental Health Assessment

IV. Social/Developmental History

- Developmental milestones
- Relevant school history
- Work/vocational history
- Current work/vocational status
- Legal issues
- Relevant family dynamics
- Drug/alcohol history
- Abuse history (emotional/physical/sexual)

Fletcher, 2009

Mental Health Assessment

Behavioral Status Review Reports

A. Recent Changes

B. Problem Behavior

C. Quality of Life Issues

Fletcher, 2009

Behavioral Status: Recent Changes: A

Name: _____ Today's Date: _____

Date of last appointment: _____ Person completing this form _____

A. Primary reason(s) for this consultation: _____

B. Life changes that have occurred within the last six (6) months

	Yes	No	Comments
1. Moves			
2. Deaths of significant others			
3. Staff or teacher changes			
4. New roommates/classmates			
5. Problems			
6. Loss of friend, pet, family member			
7. Loss of key staff/teacher			
8. Evidence of a delayed grief reaction			
9. Change in employment, program or leisure activities			

C. Acute medical problems or changes in past medical condition since last visit:

_____

Behavioral Status: Problem Behavior: B

	C	A	E	N/A	Comments
1. Is aggressive					
2. Is self injurious					
3. Appears anxious					
4. Socially isolates self					
5. Is overactive					
6. Is under-active					

Chronic: Person displays behavior on a daily basis, but severity may wax and wane

Acute: Behavior represents a dramatic change

Episodic: Periods of disturbance and periods of normal functioning

N/A: Non-Applicable

Behavioral Status:
Problem Behavior: B (continued)

	C	A	E	N/A	Comments
7. Engages in ritualistic behavior, compulsions					
8. Has self-stimulatory behavior					
9. Steals					
10. Has tantrums					
11. Is impulsive					
12. OTHER (explain):					

Chronic: Person displays behavior on a daily basis, but severity may wax and wane

Acute: Behavior represents a dramatic change

Episodic: Periods of disturbance and periods of normal functioning

N/A: Non-Applicable

Behavioral Status: Quality of Life Issues: C

Please list and explain the areas that he/she enjoys that promotes quality of life.

Family: _____

Friends: _____

Living Situation: _____

Leisure Activities: _____

Staff Relations: _____

Hobbies: _____

Work: _____

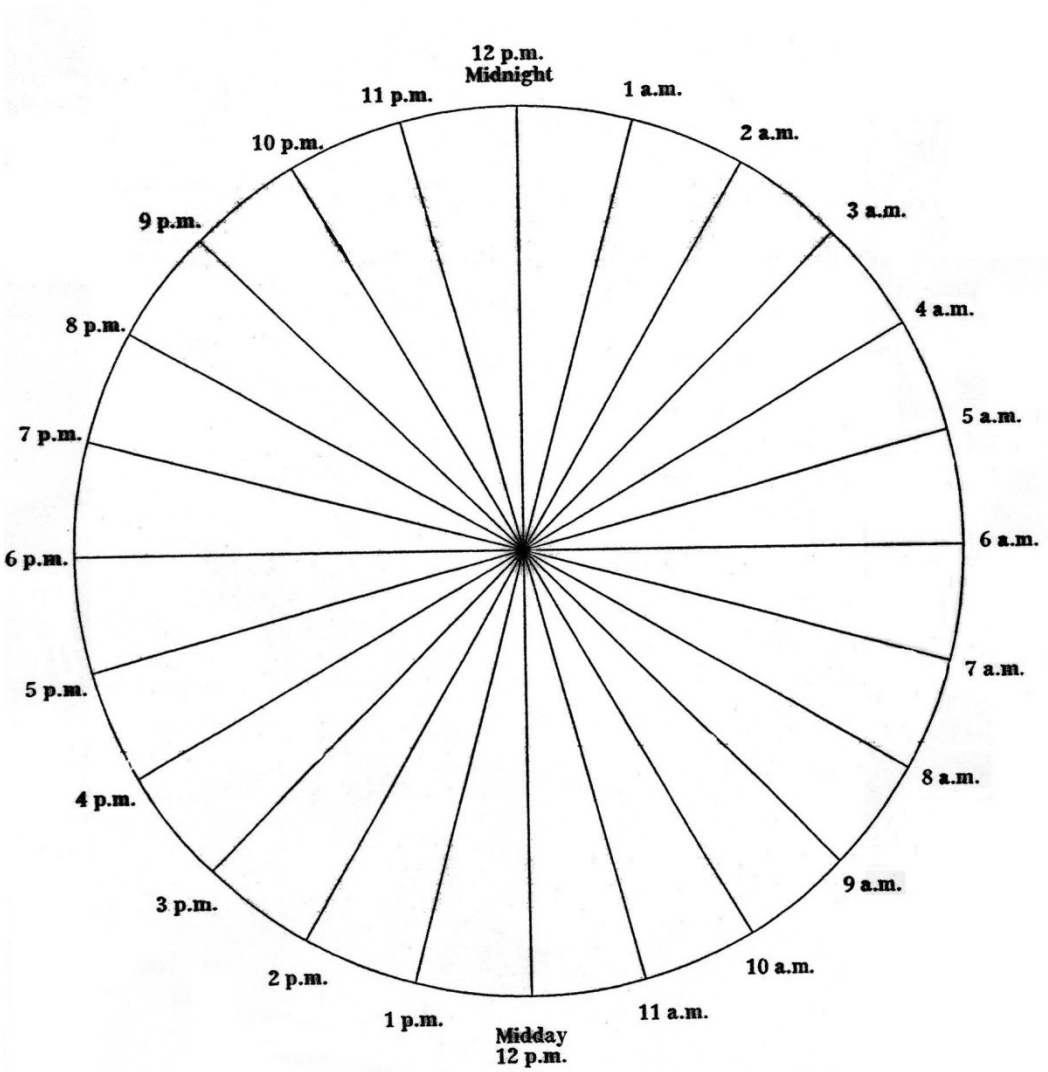
Other: _____

Minimal Data Collection

- Physical Health
- 24 Hours Sleep Data (month cycle)
- Medication Changes
- Eating Patterns
- Environmental Changes
- Mood Charting
  - Symptoms and Behavioral Manifestations

Nagy, McNelis 2001

24-Hour Framework



Sleep Patterns

Eating Patterns

Mood Patterns

Myth: Individuals with Intellectual Disability (ID) Cannot Have a Verifiable Mental Health Disorder

PREMISE:

Maladaptive behaviors are a function of ID

REALITY:

The full range of psychiatric disorders can be represented in persons with ID

DIAGNOSTIC IMPLICATIONS:

Psychiatric diagnosis can be made using the DM-ID, DSM-4TR records, service providers, family input, and client interview

Eight Diagnostic Principles For Recognizing Psychiatric Disorders In Persons with ID

1. Persons with Intellectual Disabilities suffer from the full range of psychiatric disorders

2. Psychiatric disorders usually present as maladaptive behavior

3. The origin of psychopathology is multi-determined

Adapted from Sovner 1989

Eight Diagnostic Principles For Recognizing Psychiatric Disorders In Persons with ID (continued)

4. An acute psychiatric disorder may present as an exaggeration of longstanding maladaptive behavior
5. Maladaptive behavior rarely occurs alone
6. The severity of the problem is not diagnostically relevant

Adapted from Sovner 1989

Eight Diagnostic Principles For Recognizing Psychiatric Disorders In Persons with ID (continued)

7. The clinical interview alone is rarely diagnostic

8. It is very difficult to diagnose psychotic disorders in persons with very limited verbal skills

Adapted from Sovner 1989

Barriers to Diagnosis and Treatment

15 Complicating Diagnostic Factors

1) Diagnostic Overshadowing
2) Problems with Poly pharmacy
3) Communication Deficits
4) Atypical Presentation of Psychiatric Disorders
5) Limited Life Experiences
6) Medical Conditions
7) Acquiescence
8) Learned Behavior
9) Aggression and SIB
10) Sensory Impairment
11) Behavioral Overshadowing
12) Medication Masking
13) Episodic Presentation
14) Division of Services
15) Lack of Expertise

Barriers to Diagnosis and Treatment

Complicating Diagnostic Factors (1-3)

1) Diagnostic Overshadowing

2) Problems with Poly Pharmacy

3) Communication Deficits

Barriers to Diagnosis and Treatment

Complicating Diagnostic Factors (4-6)

4) Atypical Presentation of Psychiatric Disorders

5) Limited Life Experiences

6) Medical Conditions

Barriers to Diagnosis and Treatment

Complicating Diagnostic Factors (7-9)

7) Acquiescence
8) Learned Behavior
9) Aggression and SIB

Barriers to Diagnosis and Treatment

Complicating Diagnostic Factors (10-12)

10) Sensory Impairment

11) Behavioral Overshadowing

12) Medication Masking

Barriers to Diagnosis and Treatment

Complicating Diagnostic Factors (13-15)

13) Episodic Presentation

14) Division of Services

15) Lack of Expertise

Psychiatric Symptoms/Learned Behaviors/Medication Conditions:

A Clinical Challenge

It can be difficult to distinguish whether a behavioral problem is associated with:

- **A symptom of a psychiatric disorder**
- **A learned behavior**
- **A medical condition**

Medical Problems & Problem Behavior

- Why do medical causes of problem behaviors get missed?
- Why do we have to be…….

  Sherlock Holmes

Medical Problems & Problem Behavior

Medical conditions can be present when behavioral problems are exhibited.

Medication effects / reactions can be present when behavioral problems are exhibited.

Medical conditions are often underdiagnosed.

Medical conditions can mask as behavioral problems.

Medical Problems & Problem Behavior

DRUG SIDE EFFECTS

Akathisia, Delirium, Dyskinesia

INFECTIONS

ENDOCRINOLOGICAL PROBLEMS

Thyroid problems Diabetes

NEUROLOGICAL PROBLEMS

Epilepsy Other movement problems

OTHER

Dental pain Sleep apnea Hearing and vision problems

Back pain Headaches

Medical Problems & Problem Behavior

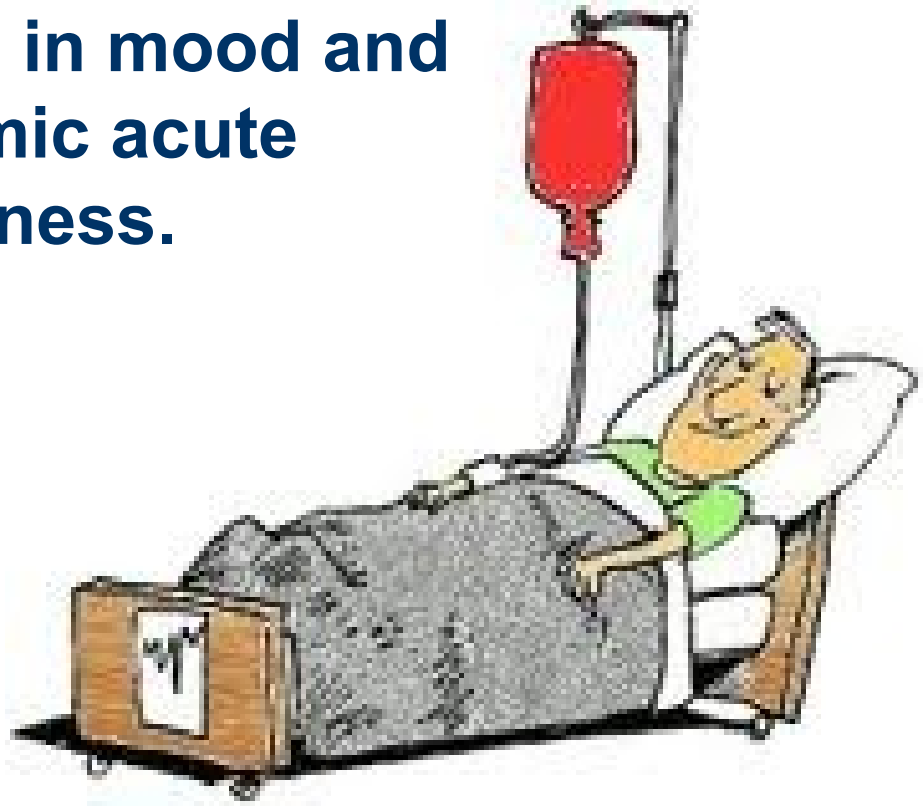
Condensed Medical Data in Chart

It is essential that all earlier medical data be available.

It is important that the past and present medical history be condensed in a format that can be easily read and placed in the person's chart.

Medical Problems & Problem Behavior

Medical Problems may cause significant alterations in mood and behavior that mimic acute psychiatric illness.



Medical Problems & Problem Behavior

Medical Problems May Cause Distress & Look Like an Acute Psychiatric Problem

Frequency of Inpatients Diagnosed with Mental Disorder d/t a Medical Problem

N = 198

Medical cause of Agitation = 82

41% = Percent of Patients with ID admitted to a psych unit, diagnosed with medical cause

Charlot, 2011

Medical Problems & Problem Behavior

Symptoms Reported by Informants :
Don't confuse phenomenology with etiology

- MANIA
  - Irritable, restless, pacing, running back and forth, can't sit still, can't focus, can't get to sleep
- DEPRESSION
  - Crying, won't get out of bed, decreased concentration
- AKATHISIA
  - Irritable, restless, pacing, running back and forth, can't sit still, can't focus, can't get to sleep
- CONSTIPATION
  - Crying, won't get out of bed, decreased concentration

Medical Problems & Problem Behavior

1. **Sleep Pattern**

   Quality and quantity of sleep can affect physical and mental health

   For example:

   a. Poor sleep ⇨ fatigue ⇨ irritability

   b. Depression ⇨ poor sleep ⇨ irritability

   c. Medical problem (discomfort caused by constipation) ⇨ poor sleep ⇨ irritability

   Assessment Strategy

   Maintain sleep data

Medical Problems & Problem Behavior

2. **Appetite Pattern**

   Changes in appetite can be clues in the assessment of mental health or physical problem

   Significant weight change may indicated a medical or mental health problems

   Assessment Strategy

   Monitor and document a person's weight on a weekly basis

Medical Problems & Problem Behavior

3. **Activity Level**

Activity level refers to the things a person usually does during the day. For example:

- going to work
- completing chores
- leisure time pursuits

Assessment Strategy

If a person's activity level changes drastically, it may be an unrecognized medical or mental health problem.

Medical Problems & Problem Behavior

4. **Activity Level**

   Examples:

   Arthritis ⇨ decreased activity ⇨ refuses to go to work ⇨ could be viewed as non-compliant

   Depression ⇨ decreased activity ⇨ refuses to go to work ⇨ could be viewed as non-compliant

Fletcher 2001

Mental Status Examination

I. General Appearance and Behavior
II. Mood and Affect
III. Psychomotor Activity and Speech
IV. Thought Process and Content
V. Cognitive Functions
VI. Judgment and Insight
VII. Multi-Axial Diagnoses

Mental Status Examination

I. General Appearance and Behavior

- Determines level of consciousness
- Assesses person's attentiveness and effective participation in interview
- Notes person's attitude toward examiner
- Assesses posture and general motor activity
- Notes facial expression
- Notes personal hygiene and grooming
- Assesses weight status

Note : All of the above is based on the cognitive developmental level of the individual with ID.

Mental Status Examination

II. Mood and Affect

- Describe predominant mood
- Describe affect including range

Note : All of the above is based on the cognitive developmental level of the individual with ID.

Mental Status Examination

III. Psychomotor Activity and Speech

- Assesses psychomotor activity and notes
  - Rate of psychomotor activity
  - Presence of abnormal movements

- Assesses speech and notes amount, volume, rate, organization of speech

Note : All of the above is based on the cognitive developmental level of the individual with ID.

Mental Status Examination

IV. Thought Processes and Content

- Assess thought abnormalities
- Evaluates the content of thought
- Notes presence of delusions, hallucinations (if so, what type of hallucinations)

Note : All of the above is based on the cognitive developmental level of the individual with ID.

Mental Status Examination

V. Cognitive Functions

- Assess patient's orientations to time, place, and persons
- Evaluate patient's attention and concentration
- Assess patient's memory
- Assess intellectual functioning

Note : All of the above is based on the cognitive developmental level of the individual with ID.

Mental Status Examination

VI. Judgment and Insight

- Assess person's judgment in general
- Evaluates person's insight in situation and illness

Note : All of the above is based on the cognitive developmental level of the individual with ID.

Mental Status Examination

VII. Multi-Axial Diagnoses

Axis I	**Clinical Disorders**
Axis II	**Intellectual Disability** **Personality Disorders**
Axis III	**General Medical Conditions**
Axis IV	**Psychosocial and Environmental Problems**
Axis V	**Global Assessment of Functioning**

Note : All of the above is based on the cognitive developmental level of the individual with ID.

Holistic Treatment Plan : Person Centered

Psychiatric Treatment:

i.e., Medications, psychotherapy

Living Environment

i.e., Natural environment or group home

Vocational

i.e., School, special ed

Health: _____

Leisure Time

i.e., Sports, indoor/outdoor activities

Family/Friends: _____

Other (Specify): _____

DEPRESSION

Depression

- **Can significantly disrupt school, work, family relationships, social life, etc.**
- **Onset tends to be more insidious and changes less dramatic (Deb et al., 2001)**
- **Increased prevalence in some symptoms as compared to typical population (Matson, 1988)**
- **Depression is among the most common psychiatric disorders in persons with ID (Lamon & Reiss, 1987)**

Depression

DSM-IV-TR Symptom for Depression	Presentation in Someone with ID
Depressed Mood	●Frequent unexplained crying ●Decrease in laughter and smiling ●General irritability and subsequent aggression or self-injury ●Sad facial expression
Loss of Interest in Pleasure	●No longer participates in favorite activities ●Reinforcers no longer valued ●Increased time spent alone ●Refusals of most work/social activities

Hughes, 2006

Depression

DSM-IV-TR Symptom for Depression	Presentation in Someone with ID
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-IV-TR Symptom for Depression	Presentation in Someone with ID
Psychomotor Agitation	●Restlessness, Fidgety, Pacing ●Increased disruptive behavior
Psychomotor Retardation	●Sits for extended periods ●Moves slowly ●Takes longer than usual to complete activities

Hughes, 2006

Depression

DSM-IV-TR Symptom for Depression	Presentation in Someone with ID
Fatigue/Loss of Energy	●Needs frequent breaks to complete simple activity ●Slumped/tired body posture ●Does not complete tasks with multiple steps
Feelings of Worthlessness	●Statements like “I’m dumb,” “I’m retarded,” etc. ●Seeming to seek punishment ●Social isolation

Hughes, 2006

Depression

DSM-IV-TR Symptom for Depression	Presentation in Someone with ID
Lack of Concentration/ Diminished Ability to Think	•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

Depression

Treatment Strategies

- Antidepressant medication
- Psychotherapy (individual and/or group)
- Regular exercise
- Regular scheduling of pleasurable activities
- Learning stress management strategies
- Social skill training
- Positive behavioral supports

Depression

Case Vignette: Mary

- Mary is a 16 year old female with moderate ID
- Lives at home with mother
- Attends special ed at local public school
- Teacher noticed Mary not participating in class, as she did in the past
- In recent weeks, Mary would yell and scream at teacher when prompted to do her class work
- Mary's performance at school declined
- She became socially isolated from peers
- Referred to school psychologist
- Psychologist suspected depression
- Psychologist referred Mary to psychiatrist

Fletcher, 2009

Depression

Case Vignette: Mary

Dx: Major Depression

Tx: Counseling by school psychologist
Antidepressant medication by psychiatrist

Outcome: Gradual lifting of depression
Return to her normal functioning within three (3) months

Fletcher, 2009

BIPOLAR DISORDER

Bipolar Disorder

- Causes mood swings
- Persons with Bipolar Disorder may have periods of mania and periods of depression as well as normal moods
- During manic episode, person will display oversupply of confidence and energy

Bipolar Disorder

DSM IV-TR Symptoms of Mania	Presentation in Someone with ID
Euphoric, Elevated or Irritable Mood	• 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 IV-TR Symptoms of Mania	Presentation in Someone with ID
Decreased Need for Sleep	• Behavioral challenges when prompted to go to bed • 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 IV-TR Symptoms of Mania	Presentation in Someone with ID
Inflated Self-esteem/ Grandiosity	• Making improbable claims (e.g., is a staff member, has mastered all necessary skills, etc.) • Wearing excessive make-up • Dressing provocatively • Demanding rewards
Flight of Ideas	• Disorganized speech • Thoughts not connected • Quickly changing subjects

Hughes, 2006

Bipolar Disorder

DSM IV-TR Symptoms of Mania	Presentation in Someone with ID
More Talkative/ Pressured Speech	• Increased singing • Increased swearing • Perseverative speech • Screaming • Intruding in order to say something • Non-verbal communication increases • Increase in vocalizations

Hughes, 2006

Bipolar Disorder

DSM IV-TR Symptoms of Mania	Presentation in Someone with ID
Distractibility	• Decrease in work/task performance • Leaving tasks uncompleted • Inability to sit through activities (e.g., favorite TV show)

Hughes, 2006

Bipolar Disorder

DSM IV-TR Symptoms of Mania	Presentation in Someone with ID
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

Bipolar Disorder

Treatment Strategies

- Mood stabilizing and antidepressant medication
- Psychotherapy with a focus on understanding and managing the disorder
- Environmental and social modification (i.e. increase supervision to insure safety)
- Positive Behavioral Supports

Bi-Polar

Case Vignette: Bob

- Bob is a 20 year old male with severe ID
- Mother reported sleep disturbance
- At school he began hitting other peers
- Mother reported weight loss
- Teacher reported increased agitation (i.e., rarely sits, fidgety, angry outbursts)
- Mother referred Bob to family physician
- Dx: Bi-Polar Disorder
- Tx: Mood stabilizing medication

- Outcome: After eight (8) weeks, Bob's behavior began to improve. At twelve (12) weeks, be was able to return to his normal daily routine without disruption

Fletcher, 2010

Overview of the Diagnostic Manual for Persons with Intellectual Disabilities DM-ID

Limitations of DSM System

- **Diagnostic Overshadowing (Reiss, et al, 1982)**
- **Applicability of established diagnostic systems is increasingly suspect as the severity of ID increases (Rush, 2000)**
- **DSM and ICD Systems rely on self report of signs and symptoms**

DM–ID

Diagnostic Manual – Intellectual Disabilities

Developed By

National Association for the Dually Diagnosed

(NADD)

In association with

American Psychiatric Association

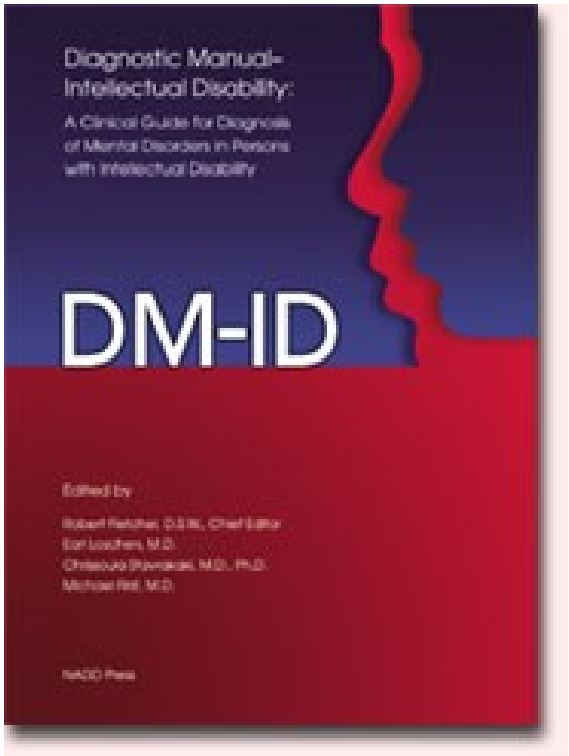
(APA)

Partial Funding from the Joseph P. Kennedy, Jr. Foundation

Published by the NADD Press, 2007

DM–ID: Two Manuals

Diagnostic Manual – Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability



Diagnostic Manual – Intellectual Disability: A Clinical Guide for Diagnosis of Mental Disorders in Persons with Intellectual Disability

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Editor of the *DSM-IV-TR*

Description of DM-ID

- An adaptation to the *DSM-IV-TR*
- Designed to facilitate a more accurate psychiatric diagnosis
- Based on Expert Consensus Model
- Covers all major diagnostic categories as defined in *DSM-IV-TR*

Fletcher, 2008

Description of DM-ID
(continued)

- Provides information to help with diagnostic process
- Addresses pathoplastic effect of ID on psychopathology (expression disorder)
- Designed with a developmental perspective to help clinicians to recognize symptom profiles in adults and children with ID

Fletcher, 2008

Description of DM-ID (continued)

- Empirically-based approach to identify specific psychiatric disorders in persons with ID
- Provides state-of-the-art information about mental disorders in persons with ID
- Provides adaptations of criteria, where appropriate

Fletcher, 2008

Two Special Added-Value Chapters

- **Assessment and Diagnostic Procedures**
- **Behavioral Phenotype of Genetic Disorders**

Assessment and Diagnostic Procedures: Chapter 2

Special Consideration

Language That Is Understandable

- Use simple language
- Create short sentences
- Check back with person for understanding
- Use of examples

Hurley, et al, 2007

Assessment and Diagnostic Procedures: Chapter 2

- Assessment of Medical Conditions
  - Constipation → distress
  - Hypothyroidism → depressive symptoms
  - Hyperthyroidism → manic episode
  - Diabetes → behavioral side effects

Hurley, et al, 2007

Behavioral Phenotype of Genetic Disorders: Chapter 3

- Angelman Syndrome
- Cri-du-Chat (5p-) Syndrome
- Down Syndrome
- Fetal Alcohol Syndrome
- Fragile-X Syndrome
- Phenylketonuria
- Prader-Willi Syndrome
- Rubenstein-Taybi Syndrome
- Smith-Magenis Syndrome
- Tuberous Sclerosis Complex
- Velocardiofacial Syndrome
- Williams Syndrome

Levitas, et al, 2007

Behavioral Phenotype of Genetic Disorders: Chapter 3

Phenotype and Proposed Behavioral Phenotype for Down Syndrome

Phenotype	**Small head, mouth; upward slant to eyes; epicanthal folds; broad neck; hypothyroidism; hearing loss; visual impairments; cardiac problems; gastro-intestional; orthopedic, and skin disorders; obesity**	
Proposed Behavioral Phenotype	**Childhood**	**Oppositional and defiant; Attention-Deficit/Hyperactivity Disorder (ADHD); social, charming personality "stereotype"**
	Adulthood	**Depressive disorders; Obsessive-Compulsive Disorder; other anxiety disorders; dementia of the Alzheimer's Type; mental disorders associated with hypothyroidism**

Levitas, et al, 2007

DM-ID
Diagnostic Chapter Structure

- Review of Diagnostic Criteria
  - General description of the disorder
  - Summary of *DSM-IV-TR* criteria
- Issues related to diagnosis in people with ID
- Review of Literature/Research
  - Evaluating level of evidence

Fletcher, 2007

DM-ID

- **Application of Diagnostic Criteria to People with ID**
  - **General considerations**
  - **Adults with Mild to Moderate ID**
  - **Adults with Severe or Profound ID**
  - **Children and adolescents with ID**

Fletcher, 2007

DM-ID
(continued)

- Etiology and Pathogenesis
  - Risk Factors
    - Biological Factors
    - Psychological Factors
    - Genetic Syndromes

Fletcher, 2007

DM-ID
(continued)

Diagnostic Criteria

DSM-IV-TR Criteria	Adapted Criteria Mild-Moderate ID	Adapted Criteria Severe-Profound ID

Fletcher, 2007

DM-ID
(continued)

Diagnostic Criteria

DSM-IV-TR Criteria	Adapted Criteria for ID (Mild to Profound)

Fletcher, 2007

DM-ID
(continued)

Adaptation of the DSM-IV-TR Criteria

1. Addition of symptom equivalents
2. Omission of symptoms
3. Changes in symptom count
4. Modification of symptom duration

Fletcher, 2007

DM-ID
(continued)

Adaptation of the DSM-IV-TR Criteria

5. Modification of age requirements

6. Addition of explanatory notes

7. Criteria Sets that do not apply

Adaptation of *DSM-IV-TR* Criteria
Change in Count and Symptom Equivalent

Major Depressive Episode

DSM-IV-TR Criteria	Adapted Criteria for Mild to Profound ID
A. Five or more of the following symptoms have been present during the same 2 week period and represent a change from previous functioning. At least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.	A. **Four** or more symptoms have been present during the same 2 week period and represent a change from previous functioning. At least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure or (3) **irritable mood**.

Adaptation of *DSM-IV-TR* Criteria

Modification of Symptom Duration

Intermittent Explosive Disorder

DSM-IV-TR Criteria	Adapted Criteria for ID (Mild to Profound)
A. Several discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property.	A. **Frequent episodes that last for at least two months** of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property.

Adaptation of *DSM-IV-TR* Criteria

Modification of Age

Antisocial Personality Disorder

DSM-IV-TR Criteria	Adapted Criteria for Individuals with ID
A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:	A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age **18** years, as indicated by three (or more) of the following:
B. The individual is at least age 18 years	B. The individual is at least age **21** years
C. There is evidence of Conduct Disorder with the onset before age 15 years	C. There is evidence of Conduct Disorder with onset before age **18** years

Lindsay, et al, 2007

Adaptation of *DSM-IV-TR* Criteria

Addition of Explanatory Note

Manic Episode

DSM-IV-TR Criteria	Adapted Criteria for Mild to Profound ID
A. A distinct period of abnormally persistently elevated, expansive or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary)	A. No adaptation. **Note: Observers may report that the individual with ID; *has loud inappropriate laughing or singing, is excessively giddy or silly; is intrusive, getting into other's space; and smiles excessively and in ways that are not appropriate to the social context.*** **Elated mood may be alternating with irritable mood**

Field Study of the Clinical Usefulness of the DM-ID

Table 1: Clinician Impressions by Level of Intellectual Disability (%YES)

Item	Level of Intellectual Disability		
	Mild N=305	Moderate N=237	Severe/ Profound N=285
Was the DM-ID easy to use (user friendly)?	72.4	68.6	62.6
Did you find the DM-ID clinically useful in the diagnosis of this patient?	74.9	67.8	66.0
Did DM-ID allow you to arrive at an appropriate psychiatric diagnosis for this patient?	85.6	83.3	80.2
Did DM-ID allow you to come up with a more specific diagnosis than you would have with the *DSM-IV-TR*?	36.1	38.0	35.9
Did DM-ID help you avoid using the NOS category?	63.2	63.3	54.9

Fletcher, et al, 2008

APPROACHES FOR

TREATMENT AND SUPPORT

Myth:
Persons with ID Are Not Appropriate for Psychotherapy

Premise: Impairments in cognitive abilities and language skills make psychotherapy ineffective.

Reality: level of intelligence is not a sole indicator for appropriateness of therapy.

Treatment implications: Psychotherapy approaches need to be adapted to the expressive and receptive language skills of the person.

Fletcher, 2000

Psychotherapy/ Counseling

- Relationship between a client and a therapist/counselor
- Engaged in a therapeutic relationship
- To achieve a change in emotions, thoughts or behavior

General Similarities Between Life Issues Faced by Adolescents without ID and Adults with ID

- Both usually dependent on others
- Both tend to be in supervised settings
- Both have cognitive limitations in terms of:
  - Problem solving
  - Impulse control
  - Concrete thought

Strohmer & Prout, 1994

General Similarities Between Life Issues Faced by Adolescents without ID and Adults with ID

- **Both struggle with issues of:**
  - **Independence**
  - **Peer group**
  - **Identity choices**
  - **Vocational**
  - **Sexual identity**
  - **Authority issues**
- **Both referred to therapy by others**

Strohmer & Prout, 1994

Types of Stress Experienced by Persons with Intellectual Challenges

I. Ordinary situations which are not typically stressful to the general population
   a. social interactions
   b. meeting new people
   c. going to public places

II. Stress from difficult to manage situations for all people. even more stress for people with disabilities
   a. Major changes in one's life
      1. job
      2. death in family
      3. home relocation
   b. Adult expectations
      1. sexuality issues: dating, sex,
      2. money management
      3. living independently
      4. employment

Duetsch, 1989


BERRY'S WORLD
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www.comics.com
" I'M AFRAID THAT YOU'RE SIMPLY GO-
ING TO HAVE TO GIVE UP STRESS."

Principles for Achieving a Therapeutic Relationship

- Empathetic understanding
- Respect and acceptance of client
- Therapeutic genuineness
- Concreteness
- Accept the client's life circumstances

Robert Fletcher, DSW, ACSW, 2004

Principles for Achieving a Therapeutic Relationship

- Be consistent
- Confidentiality
- Draw the client out
- Express genuine interest in your client
- Be aware of your own feelings

Considerations in Therapy with Persons Who Have Mental Illness and ID

Special Considerations

- Watch for pleasers
- Slow progress
- Multiplicity of problems
- Reliability of reporting
- Difficulty relating to analogies
- Problems with terminating

Confidentiality

- Nothing discussed in therapy will be released without the person's permission
- With the client's permission, the therapist will work collaboratively other care providers

Therapy Techniques for Promoting Mental Wellness

Help People Better Cope With Problems

1. Listen
2. Reflect
3. Probe
4. Support
5. Facilitate problem solving
6. Evaluate outcome

Therapy Techniques for Promoting Mental Wellness

Active Listening

- Attentive
- Interested

Therapy Techniques for Promoting Mental Wellness

Reflect

- Repeat a few words
- Reflection demonstrates active listening

Therapy Techniques for Promoting Mental Wellness

Probe

- Ask direct questions
- Avoid interrogation
- *How* and *what* questions are usually easier to answer than *why* questions

Therapy Techniques for Promoting Mental Wellness

Support

- Supportive statements indicate understanding
- Express that you care
- Acknowledge having been in a similar situation

Therapy Techniques for Promoting Mental Wellness

Facilitate problem solving

- Explore alternative options
- Support acceptable solutions

Therapy Techniques for Promoting Mental Wellness

Evaluate outcome

- Was outcome acceptable?
- Was it positive?
- What was learned?


OK -
We took our clothes off and I got on top...
When does it start feeling good?
I don't know but I already have a headache!

Therapy Techniques for Promoting Mental Wellness

Guiding Principles:

- Use language that promotes hope
- Raise expectations of what people are capable of accomplishing
- Stay focused on strengths

Fletcher, 2009

Therapy Techniques for Promoting Mental Wellness

- **Build everyone's hope, because hope is the energy that moves transformation forward**

- **Move people to the "helper" role as soon as possible**

Fletcher, 2009

Therapy Techniques for Promoting Mental Wellness

- Celebrate accomplishments
- Find ways to listen to our consumers

Fletcher, 2009

STRESS & PSYCHIATRIC DISORDER

- Stressful events may exacerbate or trigger acute psychiatric problems

- People tend to underestimate the impact of stressful life events in people with DD

RECOGNITION EXPOSURE TO STRESS

- Greater exposure to negative life events
- Peer rejection (Philips)
- Residential transfers (Berkson, Heller)
- Negative self-image (Edgerton)
- Transition (Rusch & Chadsey-Rusch)
- Sexual abuse (Ryan)
- Communication of needs (Carr)

Reiss, 2009

Predictable Crisis and Prevention

There are a number of transitional stages that an individual with ID and his or her family experience throughout the life course. Each one of these transitional stages can contribute to increased stress on the individual and family.

Each one of these transitional stages can result in a crisis situation. If we can identify these stages before they occur, and if we can provide supportive therapy, then we can work toward avoiding a crisis.

Predictable Crisis and Prevention

- Confirmation/realization of diagnosis of ID
- Birth of siblings
- Starting school
- Puberty and adolescence

Levitas and Gilson, 1989

Predictable Crisis and Prevention

- Sex and dating
- Being surpassed by younger siblings
- Emancipation of siblings
- End of education

Levitas and Gilson, 1989

Predictable Crisis and Prevention

- Out-of-home placement and/or residential moves
- Staff/client relationships
- Loss of peers, friends & parents
- Medical illness & Psychiatric Illness

Levitas and Gilson, 1989

SUPPORT STRATEGIES

1. Communication Tone
2. Environmental
3. Choice and self determination
4. Relaxation techniques
5. Verbal strategies

SUPPORT STRATEGIES

1. The Importance of Communication:

Setting the Tone

- Begin your interaction socially.
- Use a non-demanding approach.
- Give choices whenever possible.

Hughes, 2006

SUPPORT STRATEGIES

2. Environmental Contributors to Problem Behaviors

- Important to evaluate the environment
- To look for things that might be contributing to, or triggering problem behaviors

NOTE:

Important to look at environment from the person's perspective.

Gardner, Griffiths, and Nugent, 1999

SUPPORT STRATEGIES

3. Providing Choice and Self Determination

A. Guiding Principles of Choice has positive benefits:

- increases community integration
- increases adaptive behavior
- improves overall quality of life
- decreases problem behavior

Fletcher, 2006

SUPPORT STRATEGIES

4. Relaxation Techniques

The purpose is to help the individual self manage and reduce stress, tension and/or angry feelings.

Relaxation strategies distract the person from the source of the stress and places focus and appropriate behavior.

SUPPORT STRATEGIES

5. Verbal Strategy

- Verbal techniques can help an individual feel acknowledged and supported
- Verbal techniques can be used by direct care staff as well as clinical staff
  a) Validating
  b) Exploring
  c) Problem Solving

Hughes, 2006

SUPPORT STRATEGIES

5. a) Validating

Validating involves confirming the person's emotions.

An example of this is shown in the following scenario:

Jack: "Everybody around here hates me!"

Staff: "It sounds as though you are pretty angry."

SUPPORT STRATEGIES

5. b) Validating & Exploring

Validating and Exploring can be combined and involve encouraging the individual to further explain whatever it is the individual is trying to communicate

An example of this is shown in the following scenario:

Jack: "Everybody around here hates me!"

Staff: "It sounds like you are pretty angry. Can you tell me what you are so mad about?"

SUPPORT STRATEGIES

5. c) Problem Solving

Identifying the nature of the problem from the clients point of view.

Explore alternative solutions to the problem

Implement the best alternative solution

Effective Communication Strategies

There are certain communication techniques which can be very helpful in de-escalating situations. These include:

1. **Active Listening**
2. **Empathetic responses**
3. **Maintain a non-judgmental attitude**

Continued . . .

Effective Communication Strategies

4. Avoid power struggles
5. Watch your posture and body language
6. Validate how they are feeling
7. Put the choices back to the person

McGilvery & Sweetland, 2011

Crisis Management

Non-Verbal De-Escalation Strategies

It is very important to be skilled at helping to de-escalate an agitated individual. There are both verbal techniques and non-verbal techniques which can be used to de-escalate a situation. Being well prepared to use the non-verbal techniques is very important when working in settings where there are individuals who are prone to exhibit unsafe reactions when agitated.

McGilvery & Sweetland, 2011

Crisis Management

Non-Verbal De-Escalation Strategies

1. Monitor your body position and body language
2. Avoid physically putting yourself in harm's way
3. Maintain a demeanor of calmness, neutrality, and confidence

McGilvery & Sweetland, 2011

Crisis Management

Verbal De-Escalation Strategies

1. Use a calm tone of voice
2. Use reflective listening
3. Avoid threatening punishment
4. Avoid power struggles
5. Do not ignore escalations of behaviors that could lead to severe behaviors

Continued . . .

McGilvery & Sweetland, 2011

Crisis Management

Verbal De-Escalation Strategies

6. Change staffing if necessary
7. Affirm that you understand
8. Change the subject if it appears to agitate the person more to talk about it

Continued . . .

McGilvery & Sweetland, 2011

Crisis Management

Verbal De-Escalation Strategies

9. Change aspects of the environment
10. Be limit setting by reminding the person of the rules but do so in a firm, fair manner and with a non-emotional tone of voice
11. Remind the individual of the undesirable consequences that can occur if he or she engages in the behavior

McGilvery & Sweetland, 2011


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CRISIS CENTER
CHENEY

RATIONAL APPROACH TO PSYCHOPHARMACOLOGY

MYTH: MEDICATION TREATMENT IS USED TO CONTROL MALADAPTIVE BEHAVIORS

Premise:

Medication therapy directly affects behavior.

Reality:

Behaviors such as self-injury and aggression are too nonspecific to be considered as direct targets for drug therapy.

Treatment implications:

The appropriate targets for medication therapy are the changes in neurophysiological function that mediate behavior associated with psychiatric disorders.

MEDICATION TREATMENT

Pharmacotherapy is therapeutic and may be the first choice treatment for some psychiatric disorders:

- **Major depression**
- **Mania states**
- **Schizophrenia**

Medication treatment should be diagnostically related to a DSM-IV or the DM-ID

Fletcher, 2004

A RATIONAL APPROACH FOR MEDICATION TREATMENT

Used as one aspect of a balanced treatment/ habilitative approach:

- **Medication treatment**
- **Therapy/counseling**
- **Behavioral interventions**
- **Family supports**
- **Quality of life opportunities**

Fletcher, 2004

Inter-Systems Collaboration

Fletcher, 2008

Inter-Systems Collaboration

Purpose/Function of A Dual Diagnosis Task Force/Committee

- Gather relevant data/formation
- Identify strengths in service delivery systems
- Identify challenges in service delivery system

Fletcher, 2008

Inter-Systems Collaboration

Purpose/Function of A Dual Diagnosis Task Force/Committee

- Generate options for improvement in service delivery systems
- Promote cross systems education/training to enhance staff competencies
- Advocate for policy initiative that advance cross systems collaboration

Fletcher, 2008

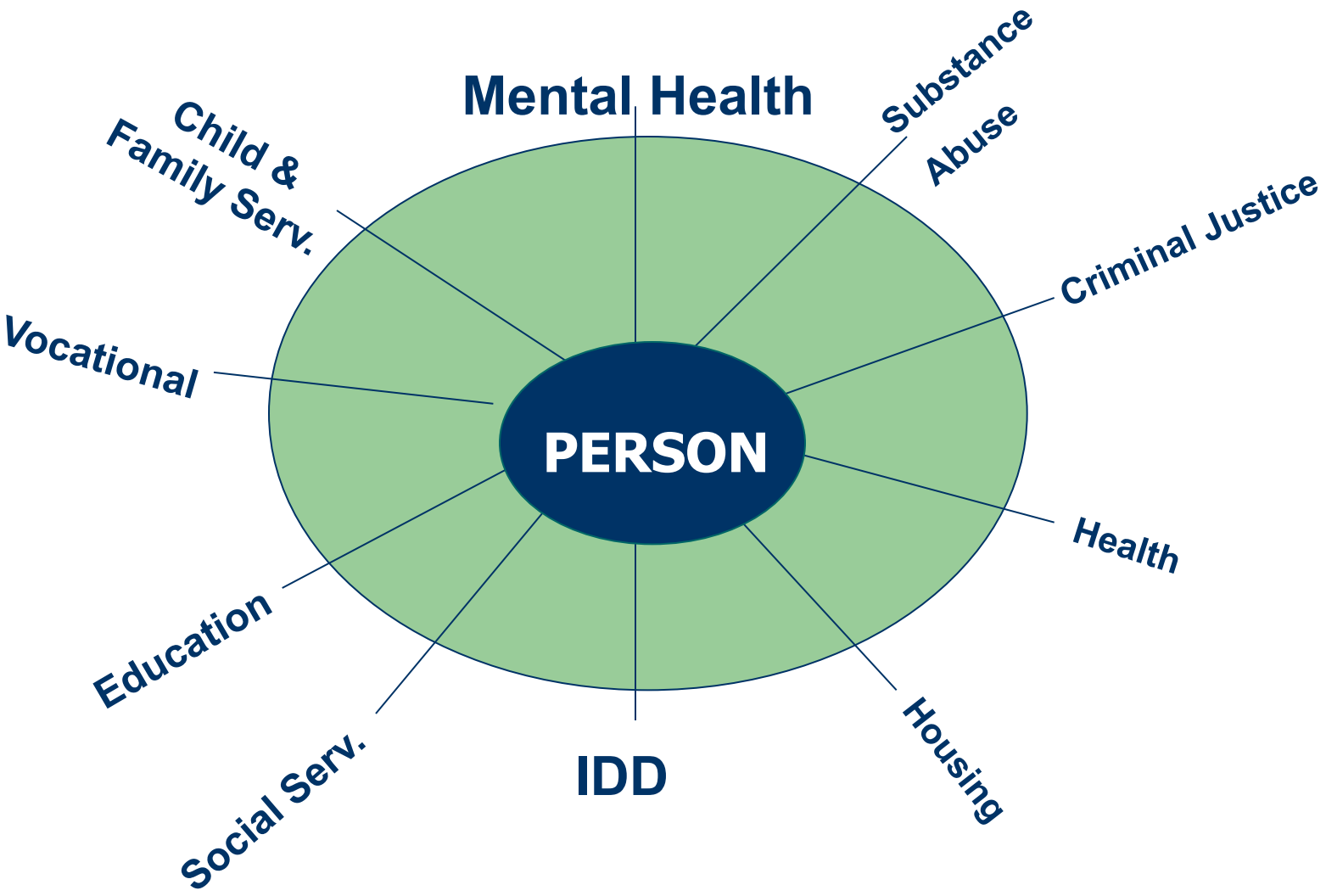
Inter-Systems Collaboration

Stakeholders from other than MH & IDD systems could be included as appropriate, perhaps on an "as needed" basis. These include, but are not limited to representatives from:

- Substance abuse
- Criminal Justice
- Health Department
- Social Services
- Parents
- Consumers
- Advocacy Organizations
- Special Education
- Early Intervention
- Child Welfare
- Coordinated Children's Services
- Service Providers

Fletcher, 2008

Inter-Systems Collaboration



Fletcher, 2007

NO
QUICK FIX

Robert Fletcher, DSW, ACSW , 2004

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