Redwood Coast Regional Center

Overview of Mental Health Disorders and IDD

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Objectives for Today's Webinar

- Review key concepts regarding the co-occurrence of mental health disorders and intellectual/developmental disabilities
- Raise awareness regarding the potentially disabling aspects of dual diagnosis (MI/DD)
- Consider what can be done on a practical and everyday basis to help people with dual diagnoses?

Some key terms used in this presentation

- Behavioral phenotypes
- Environmental stressors
- Excess Disability
- DSM-equivalents
- Dual Diagnosis (MH/ID)
- Pharmacological and Non-Pharmacological Approaches
- Best practice
- Voice and Choice

Similarities and Differences

- Developmental disabilities are life long and severe mental illness is chronic
- Developmental disorders and mental disorders can both be disabling
- There can be maladaptive behaviors associated with either IDD or mental health problems
- For instance, self-injury is a ***behavioral phenotype of autism*** whereas someone who is very depressed or anxious can be self-injurious

Person-centered versus Illness-centered care

- Driven by strengths and values rather than by diagnosis

✓Reflects holistic care

✓Reflects shared decision making

✓Helps individuals reach their valued health outcomes

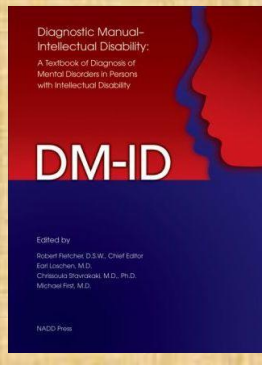
✓Considers Quality of Life

DSM Equivalents

- The criteria for mental health disorders listed in the DSM-5 may need to be adjusted to the psychiatric presentation by children and adults with intellectual and developmental disabilities

- The DSM-5 has a companion volume DM-ID 2

- S/S of psychiatric disorders may include challenging behaviors (aggression, property destruction, self-injurious behavior) not typically seen in the non-DD population



Assessment Challenges

- Diagnostic Overshadowing
- Masking
- Cognitive Distortion
- Response Bias
- Limited linguistic competency
- Need for emotional education/ poor differentiation of mood states and thinking problems

Co-occurring Mental Illness and Developmental Disability

- Dosing of medication may vary because of high occurrence of medical conditions: someone with a seizure disorder, may not be able to tolerate psychoactive meds that lower the seizure threshold

- It may take longer to stabilize individuals with IDD on medication compared with general psychiatric population due to co-occurring medical problems

Psychoactive Medications

- Antipsychotics
- Mood Stabilizers
- Antidepressants
- Antianxiety medication

NEW antipsychotics = schizophrenia, Bipolar
1. Risperidone (Risperdal)
2. Paliperidone (Invega)
3. Ziprasidone (Geodon)
4. Olanzapine (Zyprexa)
5. Quetiapine (Seroquel)
6. Clozapine (Clozaril)
7. Aripiprazole (Abilify)

"...idone" "...apine"

OLD antipsychotics = schizophrenia, Bipolar
1. Haldol (haloperidol)
2. Thorazine (chlorpromazine)
3. Prolixin (fluphenazine)
4. Trilafon (perphenazine)
5. Mellaril (thioridazine)
6. Stelazine (trifluoroperazine)
7. Moban (molindone)
8. Navane

"...azine"

Anticonvulsants = schizophrenia
1. *Depakote (valproic acid)
2. *Tegretol (carbamazepine)
3. *Lamictal (lamotrigine)

Opioid Antagonist = Opiate Treatment
1. Naloxone (Narcan)
2. *Naltrexone

"Nal..."

Benzodiazepines = Bipolar, GAD, Acute Alcohol Withdrawal &...

Schizophrenia:
1. lorazepam (Ativan)
2. clonazepam (Klonopin)

Panic:
1. lorazepam (Ativan)
2. clonazepam (Klonopin)
3. alprazolam (Xanax)
4. diazepam (Valium
5. chlordiazepoxide (Librium)

"...azepam"

Mood Stabilizers = Bipolar
1. lithium carbonate
2. *valproic acid (Depakote)
3. *carbamazapine (Tegretol)
4. oxcarbazepine (Trileptal)
5. *lamotrigine (Lamictal)
6. gabapentin (Neurontin)
7. topiramate (Topamax)

"...azepine"

-- = GAD
1. BuSpar (buspirone)

-- = Non-Acute Alcohol Withdrawal
1. disulfiram (Antabuse)
2. *naltrexone (ReVia, Depade)
3. acamprosate (Campral)
4. topiramate (Topamax))

SSRI = Depression, Panic, Bipo
1. fluoxetine (Prozac)
2. paroxetine (Paxil and Paxi
3. citalopram (Celexa)
4. escitalopram (Lexapro)
5. sertraline (Zoloft)
6. fluvoxamine (Luvox)

"...x

SNRI = Depression, Panic, OCD
1. venalfaxine (Effexor)
2. desvenlafaxine (Pristiq)
3. duloxetine (Cymbalta)

Atypical antidepressants = De
1. Nefazodone (Serazone)
2. trazodone (Desyrel)
3. bupropion (Wellbutrin)
4. mirtazapine (Remeron)

Cyclic Antidepressants = Depr OCD, GAD
1. amitriptyline (Elavil)
2. nortriptyline (Pamelor)
3. desipramine (Norpramin)
4. imipramine (Tofranil)

"...triptyl

MAOIs = Depression, Panic, O
1. phenelzine (Nardil)
2. tranylcypromine (Parnate
3. isocarboxazid (Marplan)
4. selegeline (Eldepryl)

Behavior

- The individual who is self-injurious, assaultive, property destructive or elopes may be responding to problems that are non-psychiatric in nature:

✓Response to environmental stressors by a child or adult who has poor coping skills

✓Medical illness or medical status change

✓Adverse drug response

✓Behavior is a phenotype of particular developmental disorder

Psychiatric versus Behavioral Problems

- Psychiatric illness does not cause behavior problems, but may increase the frequency, intensity or duration of unwanted behaviors

Environmental triggers and stressors

+

Poorly developed coping skills

+

Psychiatric illness

=

Unwanted/maladaptive behaviors

Persons with IDD are more likely…

- To have co-occurring medical problems
- To be impulsive
- To demonstrate challenges in self-monitoring and self-regulation
- To have difficulty with social problem solving
- To have limited self-calming skills
- To have limited language skills with which to let others know about subjective or emotional distress

What is Obsessive-Compulsive Disorder (OCD)?

- **Obsessions**= thoughts

Obsessions are thoughts, images, or impulses which repeatedly occurs and over which the person feels limited control

  - The obsession may be experienced as disturbing and intrusive. For instance, a person may have a worry or fear which he/she knows is unrealistic. However , obsessions need not be experienced as distressing…

- **Compulsions**=actions

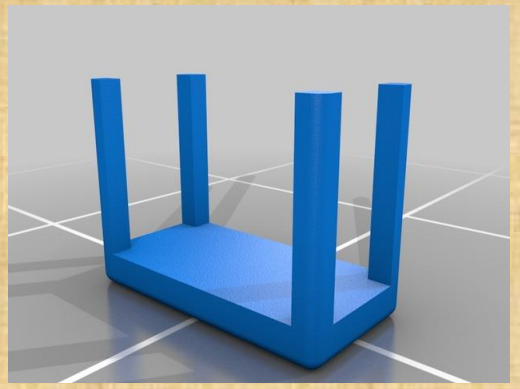
Compulsions are repetitive actions that do not serve any functional purpose but may help bind the person's anxiety

Examples of common obsessions and related compulsions

- Fear of ***contamination*** is associated with excessive washing rituals
- Fear of ***harm***ing self or others is associated with repeating
- Fear of ***losing control*** or aggressive urges are associated with checking behaviors
- Intrusive ***sexual thoughts*** or urges are associated with repetitive touching
- Excessive religious or ***moral doubt*** and counting
- ***Forbidden thoughts*** and ordering/arranging
- A need to have things ***"just so"*** and hoarding or saving

OCD among persons with IDD

- Some behaviors that might not be associated with OCD because they do not occur as frequently among OCD-affected individuals without intellectual and developmental disabilities:



  - Flipping objects
  - Swinging objects
  - Probing body parts
  - Picking/pulling skin, nose, lip, etc.
  - Pulling one's hair/eyebrows

Jamie is a young man on the spectrum with OCD

- Jamie is a 12 year old male who is high functioning on the spectrum; that is, he is considered autistic without intellectual disability
- Jamie's morning routine takes him 2 hours to complete. If interrupted, he needs to start, again, from the beginning of his routine. He often misses the bus to school and cannot get up and out of the house until late morning regardless of when he is awakened. On average, he takes 3 showers a day each lasting for at least one hour…
- Jamie's fear of contamination keep him at home because he fears contact with other children his age and he fears being outdoors
- He has no friends, and a hx of poor school attendance. He has capacity, but his OCD interferes with his functionality

IDD and Trauma

- May include physiological signs of anxiety
- May involve new separation fears
- May take the form of sleep changes
- May lead the child or adult to withdraw from usual activity and social contact
- May take the form of a new avoidance of certain people or situations
- May involve the display of highly sexualized behaviors or aggression

Trauma-Disorder of Extreme Stressors

- Trauma incidence tends to be under-reported in the population of individuals who meet criteria for PTSD
- The trauma associated with behavioral problems (aggression to others, property destruction, self-harm, elopement, non-compliance) tends to be missed with a focus on behaviors
- Trauma has:

Emotional consequences

Cognitive consequences

Relational consequences

Bipolar Disorder

- Cyclic mood disorder can be characterized by variations between two extremes: depression and mania
- Bipolar I disorder may be associated with psychotic features
- Bipolar II disorder may include hypomanic episodes and not full-blown mania
- Disturbance in sleep, appetite and energy level, regression in skills are all prominent in active phases of mood disorder

Thought Disorder

- Problems with reality based thinking
  - Hallucinations, most likely auditory
  - Delusions; grandeur, persecution, etc.
  - Poor reality testing
  - Schizophrenia, Schizoaffective Disorder, Psychotic Disorder, NOS

- No more prevalent in MI/DD population than in general population.
- Concern regarding misdiagnosis
- Concern about the use of anti-psychotics to treat non-psychotic disorders

Impulse control disorder?

- In a population of individuals with IDD, there will be heightened neurobehavioral problems associated with compromised CNS functioning
- To what extent is impulsivity (anger, sexual, etc.) a byproduct of developmental disorder?
- To what extent does a person meet criteria for a psychiatric disorder such as Impulse Control Disorder or Intermittent Explosive Disorder?

The Role of the Psychiatrist

- A psychiatrist is a physician who specializes in the diagnosis and treatment of mental health disorders
- Psychiatrists prescribe and oversee the medical treatment of mental illness through the use of psychoactive medications
- Most psychiatrists do not offer therapy along with medical treatment of mental health disorders
- In some cases consumers see Advanced Nurse Practitioners (APN) who are supervised by Psychiatrists

Referral to Counseling

- The consumer needs to be verbal enough and have sufficient receptive as well as expressive language skills in order to be successful in counseling
- The consumer needs to be motivated to better understand and change maladaptive behaviors
- The consumer needs to be willing to work with the counselor/therapist; successful counseling cannot be mandated by others

Counselor

- Work with the consumer on building social and emotional coping skills
- Help the consumer look at his own behavior and become a better self-monitor of mood, thinking and behavior
- Help the consumer develop more effective coping strategies to deal with everyday hassles and stressors
- Incorporate wellness and recovery principles into daily activity

Behavioral Problems May Be Due to…

- Learned maladaptive behavior
- Poor social and emotional coping skills
- Central nervous system dysfunction
- Behavioral phenotype of a developmental disorder such as self-injury in Lesch-Nyan Syndrome or Cornelia de Lang syndrome
- Psychiatric disorder
- Medical/drug-induced disorder

The Behavior Specialist

- The Behavior Interventionist should be someone who knows about the principles of learning and how to apply learning theory to develop a plan that reduces unwanted behavior and increases adaptive replacement behaviors/skills

- The Behavior Interventionist needs to work alongside the consumer, family and staff in order to increase everyone's competencies in dealing with stressors

Positive Behavior Support

- **What is Positive Behavior Support?**
  Positive Behavior Support (PBS) is a set of research-based strategies used to increase quality of life and decrease problem behavior by teaching new skills and making changes in a person's environment. Positive behavior support combines:
- ***Valued outcomes;***
- ***Behavioral and biomedical science;***
- ***Validated procedures; and***
- ***Systems change to enhance quality of life and reduce problem behaviors.***

www.apbs.org

How can we help families?

- Keep them “in the loop”
- Explain the process of evaluation and how findings will be used to plan services, treatments and supports
- Explain the need for hospitalization, if this is indicated
- Explain the need for medication, if this is indicated
- Identify the individual’s rights, particularly if he or she is not a self-guardian or self-advocate

How Can Families Help?

- Understand the nature of their relative's mental health disorder including usual medications that are effective in treating the specific mental illness
- Encourage their relative to resume usual routine and expectations as soon as possible to the extent tolerated
- Work alongside staff to provide supports, and opportunities to develop age appropriate social and emotional coping skills

Helping caregivers help the consumer

- Educate caregivers regarding what they should observe and report. Train on the use of an A-B-C and/or behavioral frequency chart
- Ask caregivers to develop a timeline for changes in behavior and functioning
- What can be used to help the person who is unable to self-calm?
- Work with caregivers to become problem solvers including on-going review of what works and does not work

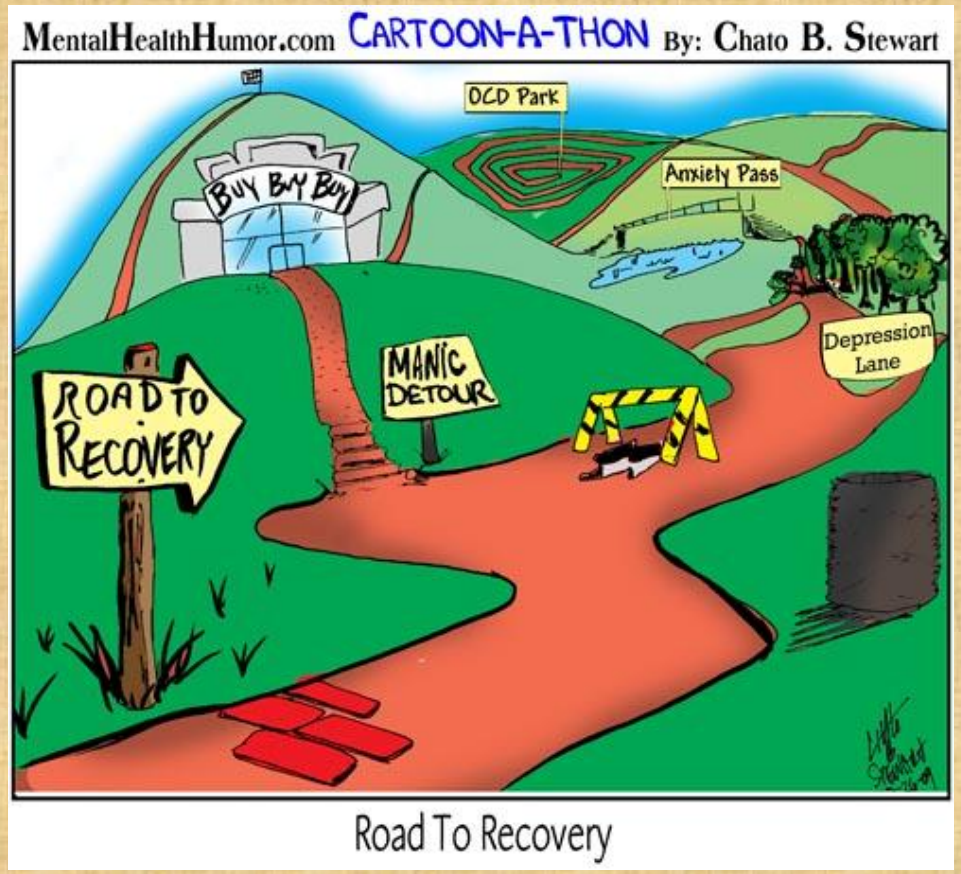
Danger+Opportunity

Crisis versus Problem Behavior

- Problem behavior tends to be of longer term duration (the individual who has been exhibiting the same behavior for several months or years)
- Problem behavior tends to be the product of a mismatch between environment and the consumer's needs
- Like crises, problem behavior may be the result of poor handling techniques, unaddressed mental health or medical issues
- Often attributable to delirium, pain, extreme stressors or maladaptive coping style
- Unlike crises, problem behaviors (which may be disruptive, annoying, counterproductive) are not necessarily dangerous

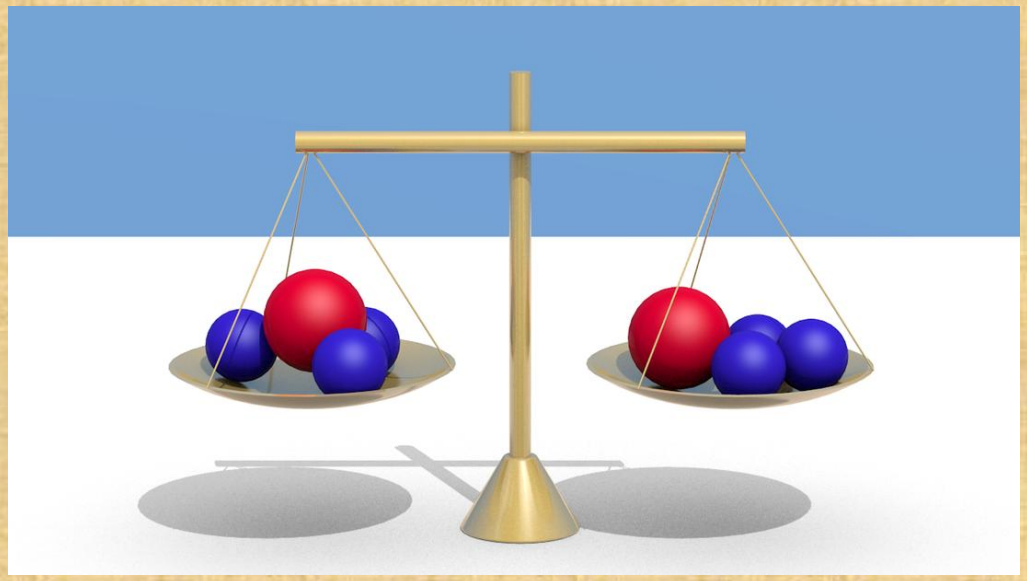
Approaches that can help…

- Best practice involves medical and non-medical interventions



Road To Recovery

Navigating Wellness



How to balance duty to care with support for choice, voice and self-determination

- We are trained to assist vulnerable individuals and act in ways that help keep them safe, but…
- Are we providing opportunities for choice, self-expression and self-determination?
- Do behavioral health challenges and the need for care preclude the rights of individuals to live in accordance with their values and preferences?

Treatments, supports and services?

Considerations:

Safety
Independence
Interdependence
Choice
Voice

Choice in Wellness and Recovery

Personal Choice

- Does the individual know he/she has choices?
- Are individuals asked about their preferences for treatment and providers?
- Opportunities for choices should be included in every activity
- To what extent would providing individuals with choice lessen the likelihood of behavioral problems?
- The opportunity to voice preference or indicate preference should be encouraged in every activity

RCRC Monthly Mini-Clinics

- Identify individuals with dual diagnosis and who would benefit on a daily basis from non-pharmacological supports and interventions:
- Functional communication
- Positive daily routine
- Staff and family training to increase communication effectiveness
- Skills building
- Comfort kits and stress management techniques

Functional Communication

- Individuals with limited language skills need opportunities to express their wants, needs and preferences
- Picture Exchange Communication Systems (PECS)
- Communication Boards
- Pictorial Calendars
- Translators

Positive Routine

- Includes choice in activities
- Meaningful work and activity
- Balances necessary tasks with preferred activities
- Provides opportunities for social connection
- Provides opportunities for skills building
- Includes opportunities for exercise and movement

Skills Building Opportunities

- **Life Skills training opportunities**

✓**ADLs to improve functional outcomes**

- **Social skills training opportunities**

✓**Social stories to improve social understanding**

- **Anger management**

✓**Coping skills**

- **Stress management**

✓**Relaxation techniques**

Wellness and Recovery Advocacy

EDUCATE!

- ❖Place Mental Health on the Civil Rights and Disabilities Agenda through trainings, seminars and events
- ❖Provide individuals, their families and all members of the valued team with information about how dual diagnosis impacts everyday living
- ❖Use the Wellness Recovery Action Plan **http://mentalhealthrecovery.com/wrap-is/**
- ❖Help all members of the valued team understand the stressors and hassles of everyday living with illness and recovery
- ❖Help people navigate the acute care system

Extension for Community Healthcare Outcomes

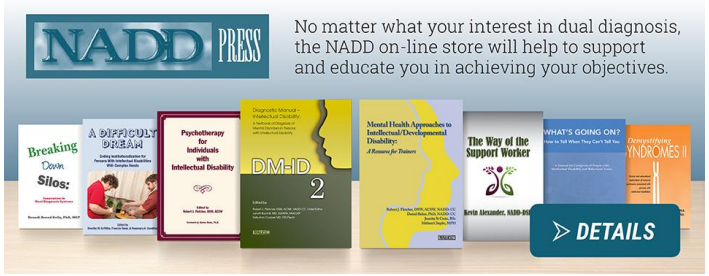
- RCRC will be holding monthly ECHO sessions that:
- Build local workforce capacity to assist individuals with complex needs
- Establish a learning collaborative around practice areas for which there is a dearth of qualified providers
- Democratize, problem solve and move relevant knowledge to where it is needed rather than move people to providers with relevant knowledge
- *Watch this space!*

Project ECHO®

Surround Yourself with Like-minded Associates…

- Join the National Association for Dual Diagnosis **www.theNADD.org**
- Lobby MCOs in your state to include practitioners with knowledge of dual diagnosis on their health panels
- Ring the Bell!

http://www.mentalhealthamerica.net/bell



Questions?

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