

* Psychiatric Care for Those with Intellectual Disabilities and Comorbid Behavioral Health Issues

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- *No financial conflicts to report

- *Things to know about me:

 - *Consult with Schreiber Center

 - *Supervised/Managed Puente Clinic

 - *Contributor: Coalition for Compassionate Care of California Conservatorship Report

*Disclaimer

Identify the general categories of intellectual disabilities

Describe two challenges in diagnosing comorbid psychiatric conditions

Assess for the three common medical comorbidities in this population

Consider solutions for three challenges in medication treatment for people with intellectual disabilities

Practice three principles in treating and coordinating the behavioral health care of people with intellectual disabilities

*Objectives

Overview



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graph TD; A[Overview] --> B[Diagnosing Psychiatric Comorbidities]; B --> C[Medical Comorbidities]; C --> D[Management and Treatment]; D --> E[Discussion];
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Diagnosing Psychiatric Comorbidities

Medical Comorbidities

Management and Treatment

Discussion

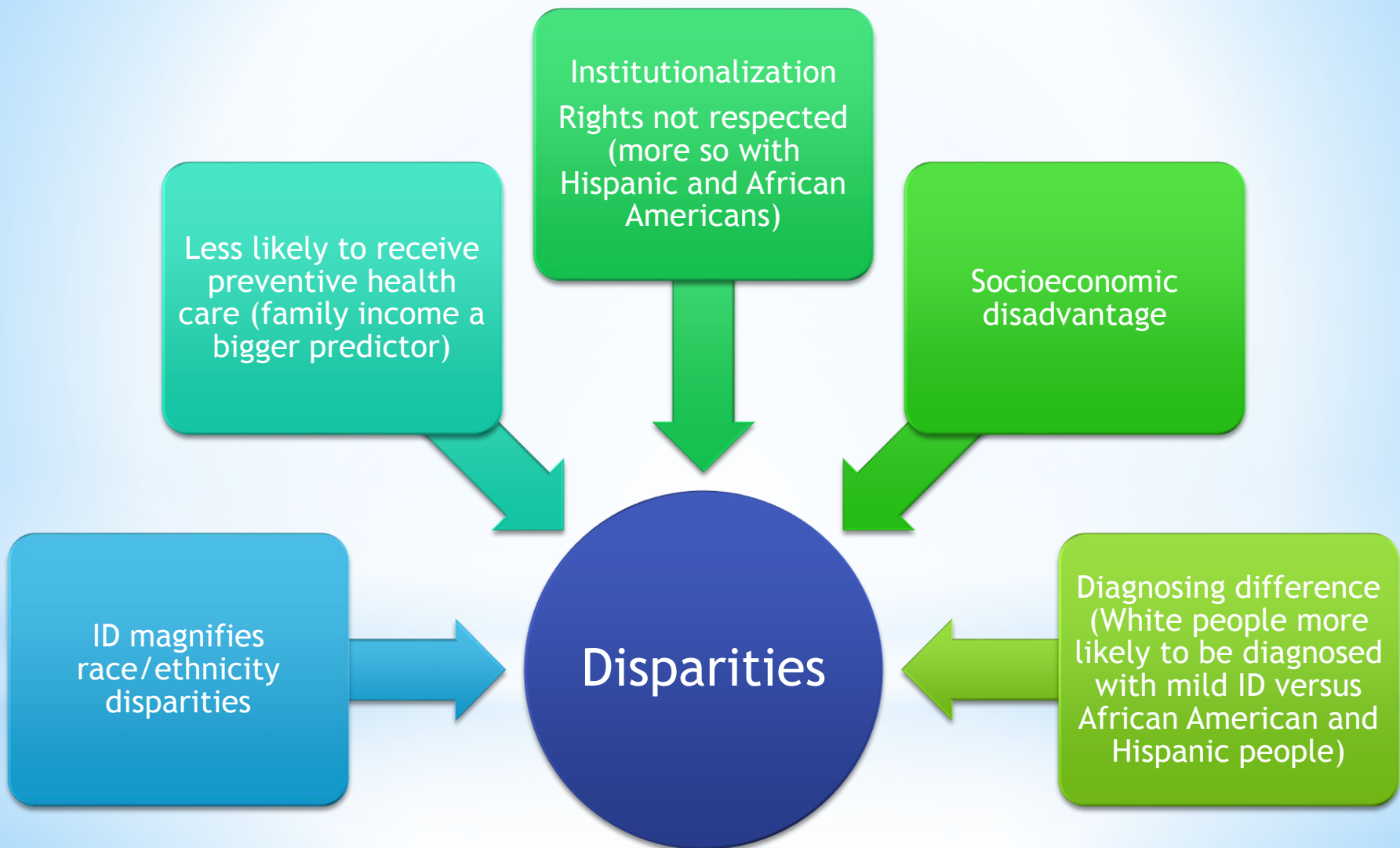
*Agenda

General
Categories
Distinctions

*Overview

- * 2-3% of the general population
- * Most (75-90%) have mild intellectual disability
- * About 25% of cases are due to a genetic disorder
- * Die 17-18 years younger than the general population

* General



Severity

- Borderline
- Mild
- Moderate
- Severe
- Profound

Causes

- Genetic
- Pregnancy/Birth
- Exposure
- Deficiencies
- Damage/Injuries

*Categories

Neurodevelopmental disorders

Intellectual Disabilities

Communication Disorders

Autism Spectrum Disorder

Attention Deficit Hyperactivity Disorder

Specific Learning Disorders

Motor Disorders

Tic Disorders

* Distinctions

*Diagnosing Psychiatric Comorbidities

Screening, signs and symptoms

Diagnosing

Approach

- Link complaints to behaviors and causes
- Detective and anthropologist

Individual

- Verbal
 - Likely will be concrete
- Behavioral
- Adaptive/Maladaptive

Collateral

- Antecedents
- Behaviors
- Reinforcing/Extinguishing

***Screening**

Avoid

Use

Caregiver opinions

Overly complex questions

Generalizations

Caregiver observations

Behaviors as proxy for emotions

Objective diagnostic criteria

Diagnostic criteria framework

*Signs and Symptoms

Diagnostic Assessment for the Severely Handicapped-II (DASH-II)

- Intended for adults with severe or profound Intellectual Disability

Aberrant Behavior Checklist (ABC)

- Adults and children - various levels of functioning

Developmental Behavior Checklist or Nisonger Child Behavior Rating Form

- Parent and teacher versions - for children

* Instruments to consider

Objective elements

- Readily applicable to this population

Subjective elements

- May need to gather collateral

Adaptations

- Minimal except for derealization or depersonalization symptoms

* Diagnosing: Anxiety

Objective

- Neurovegetative or activation symptoms similar
- Episodic nature similar

Subjective

- May need to look at behavior
- Collateral

Adaptive

- Depression - include irritability
- Mania - harder to get grandiosity

* Diagnosing: Mood Disorders

Objective

- Remain within framework of criterion A

Subjective

- Self-talk is common

Adaptive

- None specific to Intellectual Disability

* **Diagnosing: Psychotic Disorders**

Objective

- Global impairment
- Observed in multiple settings

Subjective

- Self report can be tricky

Adaptive

- Take into account person's developmental "age"

*Diagnosing: ADHD

Conduct

- Review pattern
- Discern deliberate nature of behaviors

Oppositional Defiant

- Review pattern
- Determine if caregivers are not attuned to developmental age of person

Impulse Control

- Establish pattern
- Not explained by any other condition

* Diagnosing:
Disruptive/Impulse Control
Disorders

*Medical Comorbidities

Epilepsy
Dental
Cardiovascular Conditions
Pulmonary
Cancer

Coordinate with
Neurology

Caution with
Medications

Use most
efficient and
effective
combinations

Distinguish post-
ictal behaviors

*Epilepsy

Assessment

Coordination

Likely not
getting
adequate dental
care

*Dental

Address as you
would other
patients

Attention to
physical activity
and diet

Genetic defects

Coordinate with
PCP

*Cardiovascular

Higher risk for:

- Infections
- Poorer management

Obstructive
Sleep Apnea

COPD

Pneumonia

*Pulmonary

Preventive
Care issues

Screening
barriers

*Cancer

*Management and Treatment

Pharmacology
Behavioral
Structural
Coordination

Targeted

- Clarity
- Expectations

Prudent

- Minimize polypharmacy
- Minimize interactions

Reassessed

- Is this med still appropriate?
- Are behaviors due to a medication?

* Pharmacology:
Principles

CYP 450

3A4

2D6

Protein Binding

Depakote/valproic acid

Potentiation

Benzodiazepines
and Opiates

Sedation

Anticholinergics

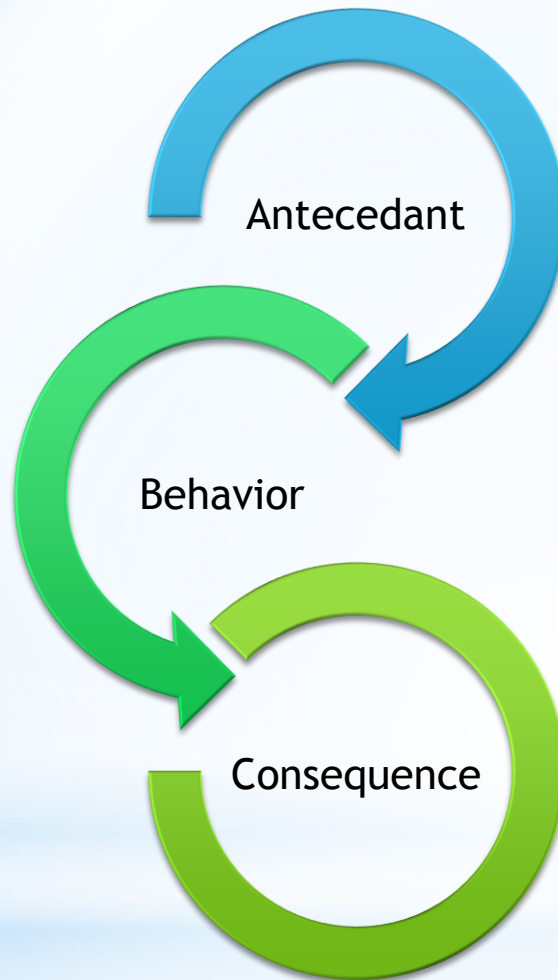
* Pharmacology:
Interactions

Melatonin
useful in this
population

Behavioral
modification

Environment
modification

*Insomnia



* Behavioral

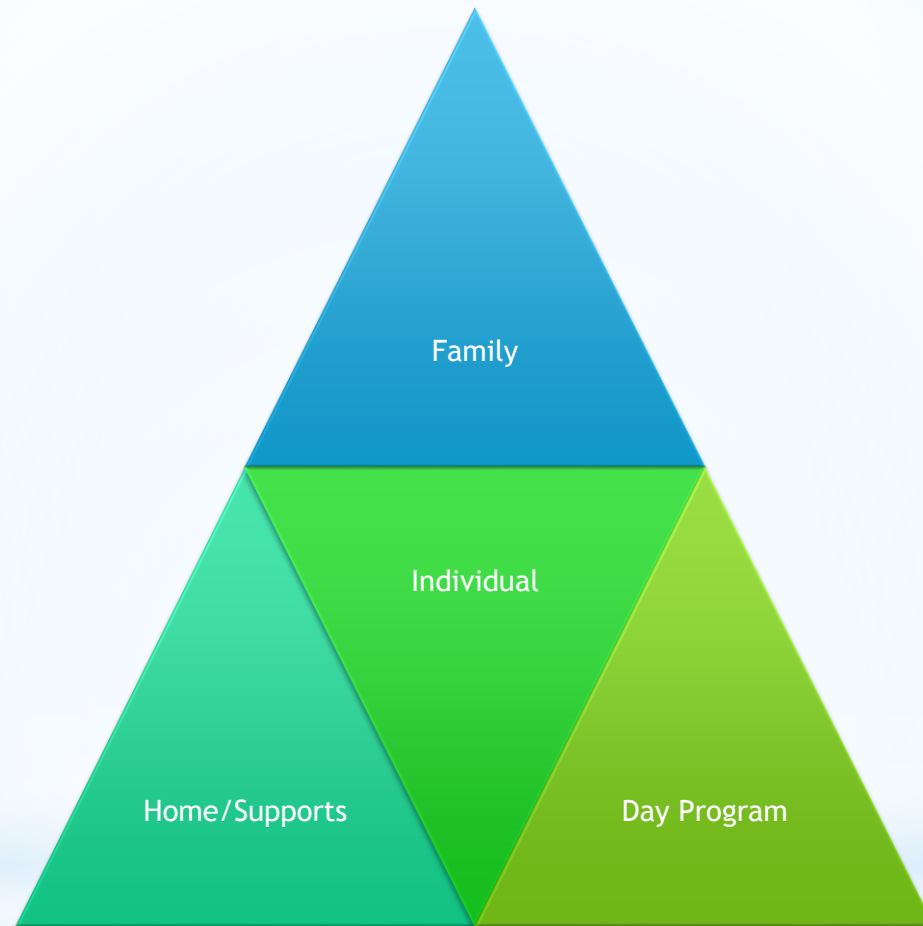
Consider

- Circumstance and environment
- Perspectives
- Contributing factors
- Function of behavior
- Nature, extent, and frequency of behavior

Positive behavioral supports include

- Person-centered design/consideration
- Least restrictive
- Teach new skills
- Reinforce positive behaviors
- Preventing ongoing reward or challenging behaviors
- Staff/family who are trained

*Behavioral



*Structural



*Coordination

*Discussion

Great Resources:

Diagnostic Manual for Intellectual Disabilities (DM-ID)

Schreiber Center

*Thank you

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