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Treatment of Mental Illness in People with an Intellectual Disability

Presented by Dr Tareq Abuelroos and Dr Chad Bennett
Victorian Dual Disability Service
28/5/2024

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Acknowledgement of Country

The Victorian Dual Disability Service would like to recognise the traditional owners of the country where we live, work and meet. We recognise and celebrate the diversity of Indigenous people and their enduring cultures and connections to the land and waters of Victoria. We pay our respects to elders; past and present, and recognise the Indigenous people that contribute immensely to mental health and disabilities services.

Artwork by Mandy Nicholson

Acknowledgement of Lived Experience

We would also like to acknowledge the immeasurable contributions of people with a lived and living experience of mental illness, psychological distress, alcohol and other drugs, and disability, as well as those who love, have loved and care for them.

We acknowledge that each person's experience is unique and valued. We recognise their adverse experience of stigma, but also their strength and resilience. We respect and value their generous contributions which teach us, and guide us to continually shape, reflect upon and deliver quality care, from a lived experience perspective.

Artwork by Zeva Mirankar

Victorian Dual Disability Service (VDDS)

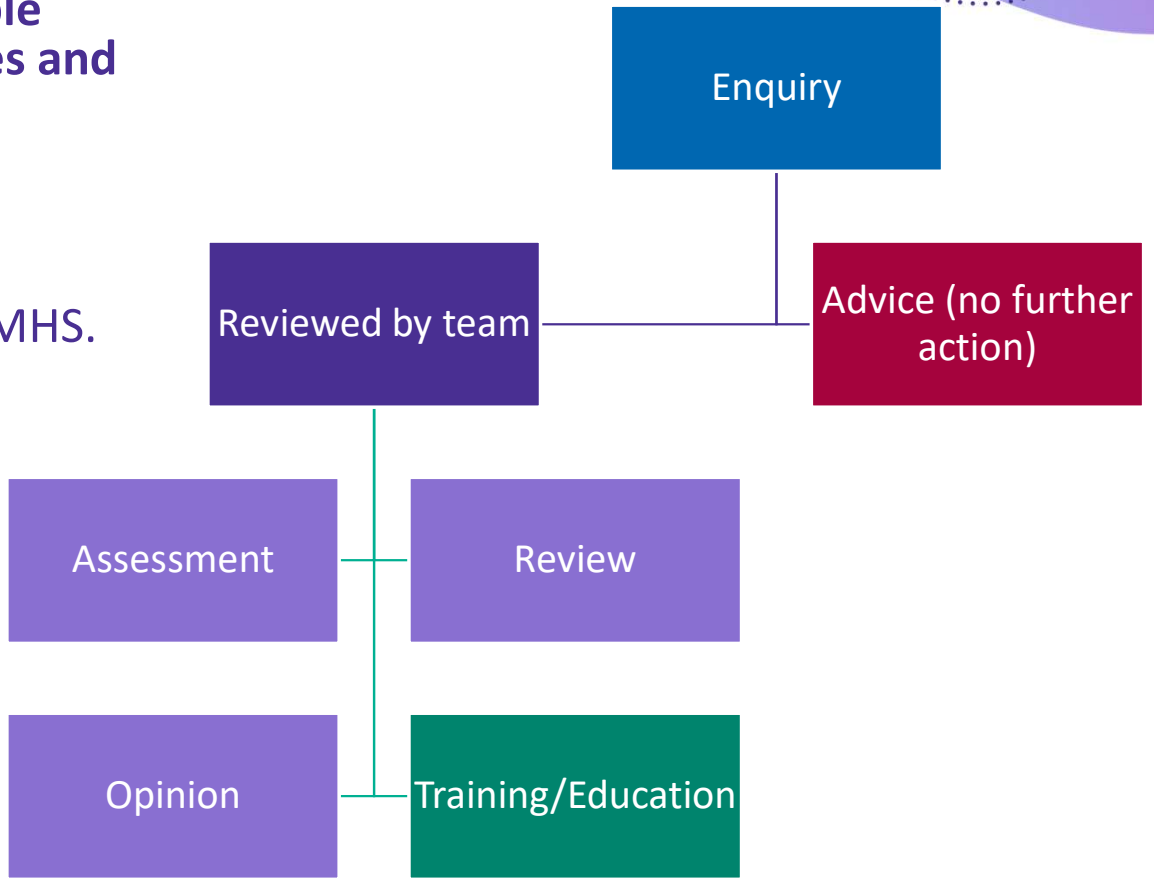
State-wide mental health service for people with co-occurring mental health challenges and a developmental disability.

What does VDDS do?

- Telephone consultation to anyone.
- Assessment & consultation for public AMHS.
- Assessment & consultation for NDIS participants
- Education & Training
- Service Development

How to make a referral or request training:

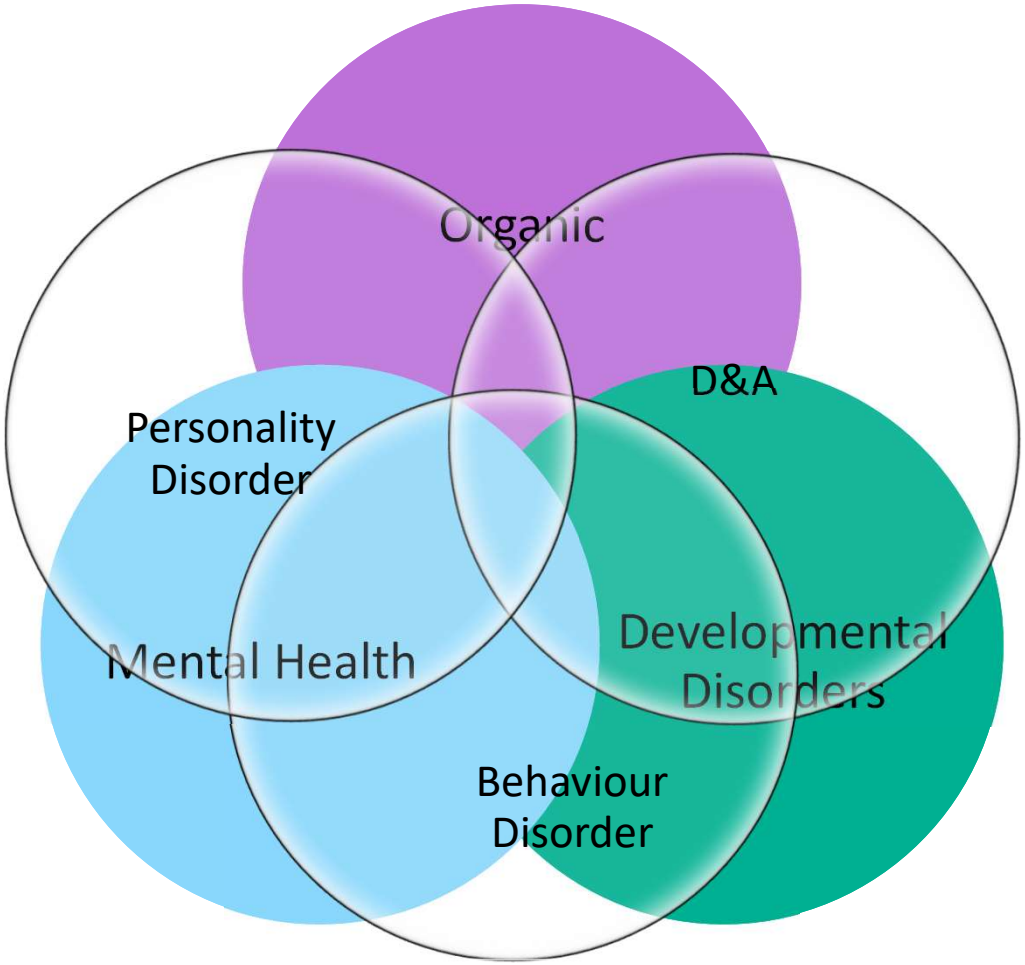
- *Telephone Referral: (03) 9231 1988*
- *Email: vdds@svha.org.au*



AIMS

1. Identify difficulties in managing people with intellectual disability and co-morbid mental disorders.
2. Review modifications to practice
3. Revise the biopsychosocial approach.
4. Highlight the principles that inform good management practice

Consumer / Patient Difficulties



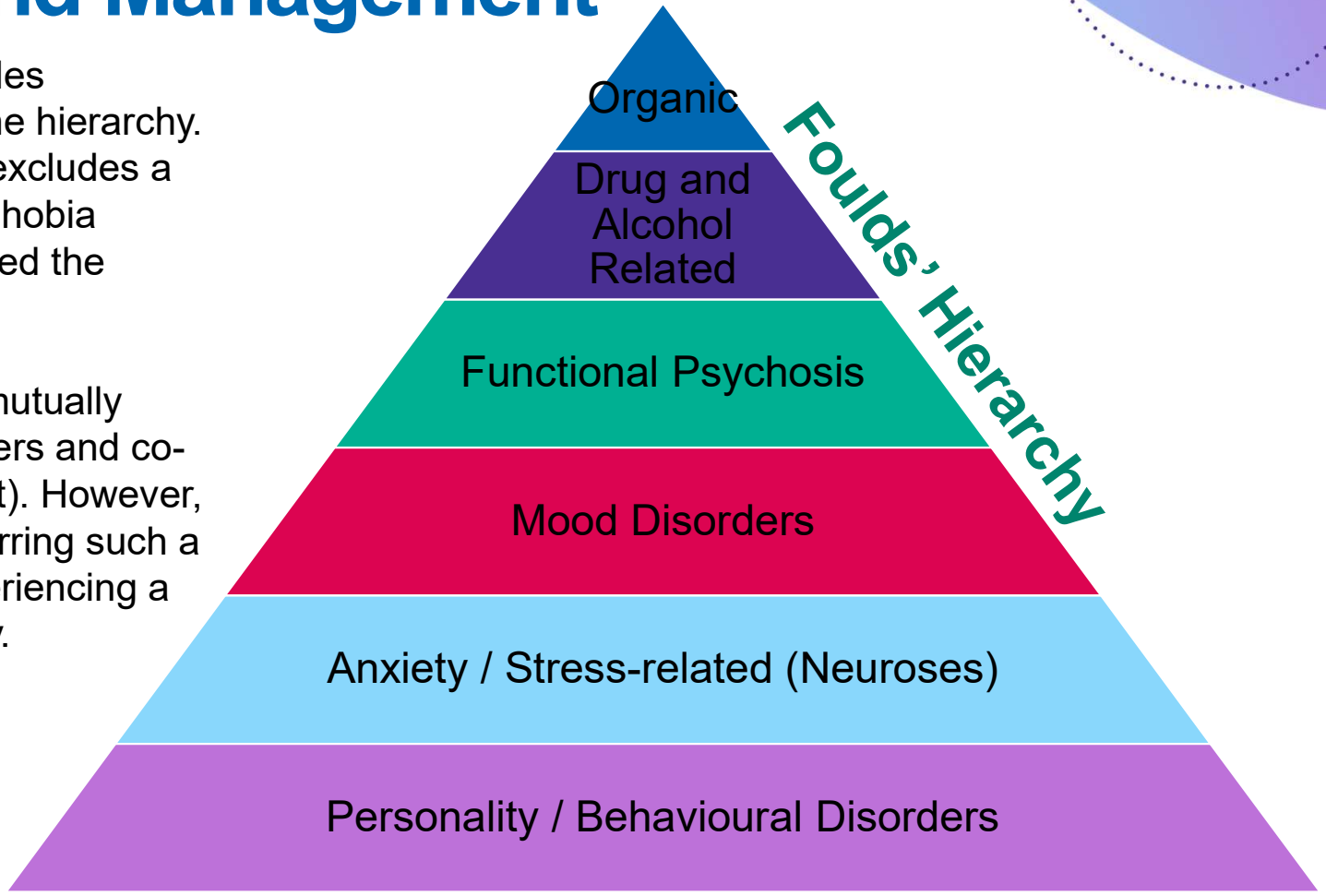
Things to Consider

Possible Cause	Potential Areas of Focus
Physical	Pain, seizure, medication, sleep, allergies, GI issues, dental, vision, hearing
Genetic	Could it be related to a genetic syndrome?
Mental Health	New or unusual behaviour, increase or decrease in pre-existing behaviour
Cognitive	Demands too high / low for cognitive level?
Communication	Adequacy of communication
Sensory	Unmet or overwhelming
Environmental	Location, time, setting, activity
Family / Staff	Changes, adequate understanding of ID

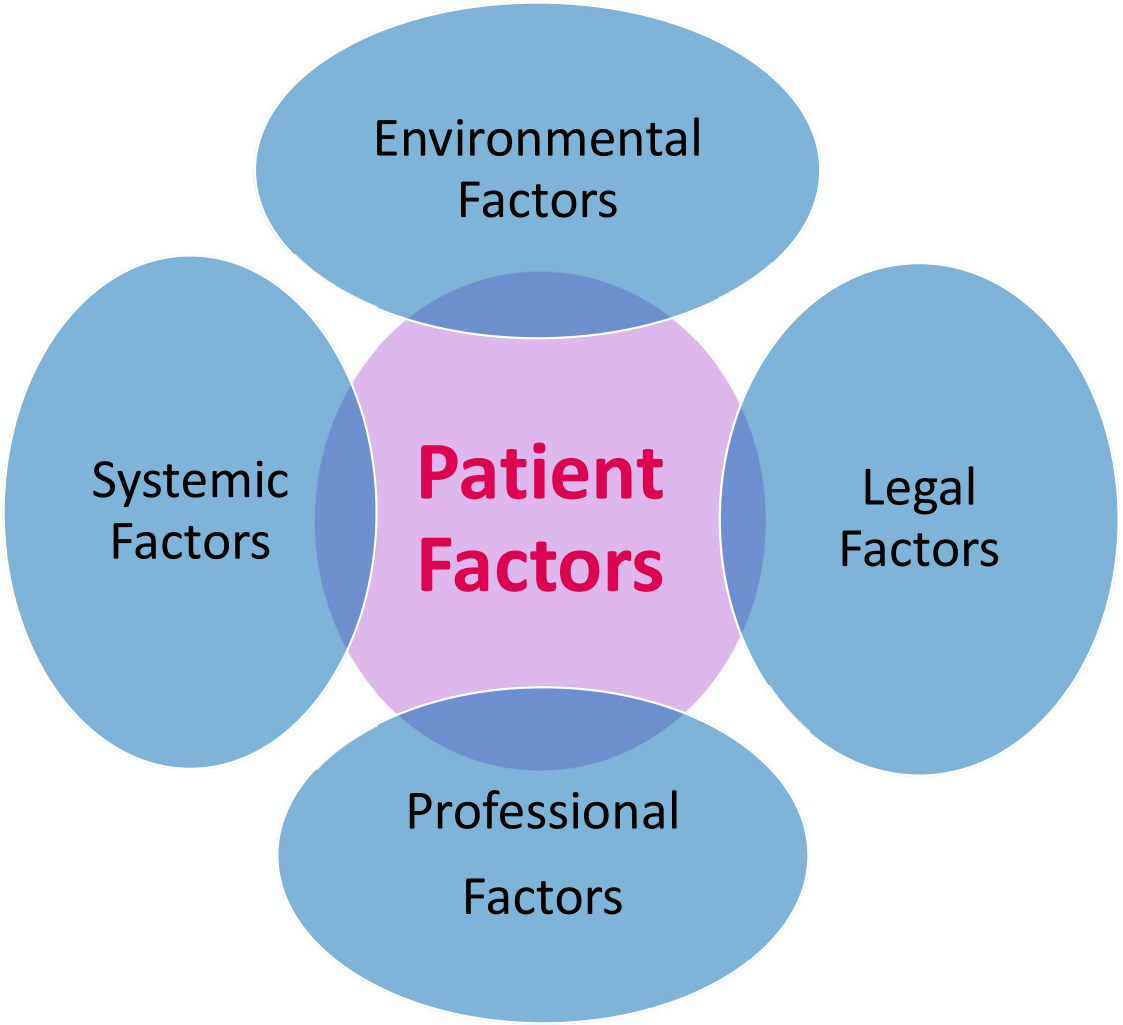
Assessment and Management

Diagnosis at a given level excludes symptoms from lower levels in the hierarchy. For example, major depression excludes a subsequent diagnosis of social phobia (unless the social phobia preceded the depressive episode).

Note that all diagnoses are not mutually exclusive (i.e. personality disorders and co-occurring depression can coexist). However, caution should be taken in conferring such a diagnosis when a patient is experiencing a condition higher up the hierarchy.



The Wider View



General Principles of Management

Consent / Legal Framework

Manage risks

Rule out organic issues

Establish:
- Baseline severity
- Goals of treatment
- Follow-up / monitoring procedure

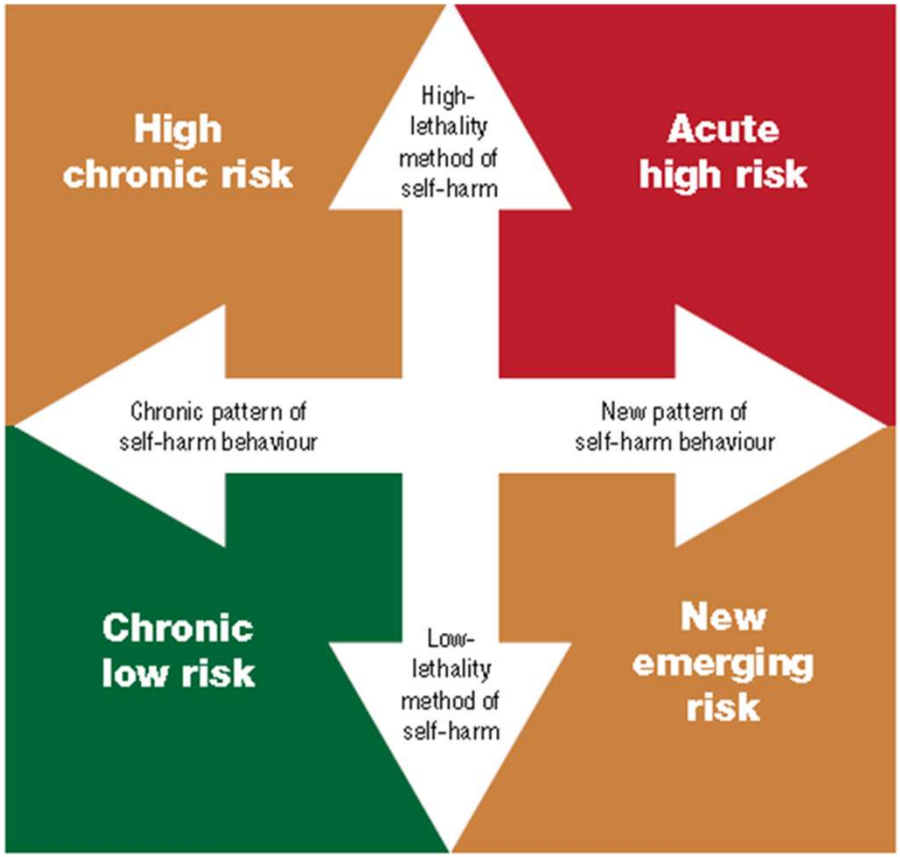
Address comorbidities

Bio-psycho-social-environmental approach

Legal and Systemic Considerations

Consent	Legislation	Services
• Freedom from coercion • Capacity • Communicate	• Mental Health and Wellbeing Act • Guardianship Act • Medical Treatment Act • Disability Act	• Disability Services • NDIS Services • Mental Health Services

Level of Risk



Adapted from Spectrum (personality disorder service for Victoria: www.spectrumbpd.com.au)

- Same types of risks as general population (suicide, self-harm etc.) PLUS additional
- Lower risk of suicide
- Lower risk of homicide
- ? Higher risk of violence (often undocumented and not charged)
- High rates of self harm (different pattern)
- Vulnerable to abuse
- Vulnerable to discrimination and exclusion
- Neglect, choking, accidental death, medical complications

Ask yourself…

What '*reasonable adjustments*' would you make to your practice in relation to managing someone with Intellectual Disability?

Reasonable Adjustments

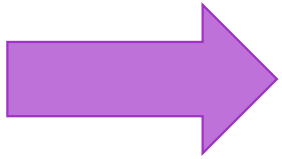
Identify at point of entry
Low threshold for service provision
Data collection
Guidelines (policy)
Protocols with other service providers (GP, police, NDIS, local service providers, emergency, medical services)
Resources (rooms, wheelchair access, rating scales, modified information, staff, space, sensory modifications)
Adapt the unit/clinic environment and programming to create therapeutic spaces and activities appropriate for patients with ASD or ID
A longer inpatient length of stay
Supervision/training/professional development to establish competence
Access to specialist services (second opinion, epilepsy, medical, surgical)
Provide direct care staff with training specific to working with patients with ASD or ID

Biological Interventions

Evidence & Prescribing Challenges

Little evidence specific to ID

- Few good trials
- Small samples
- Diagnostic difficulties
- Methodological flaws
- Ethical constraints



- Excessive dose
- Polypharmacy
- Unclear indication (e.g. behaviour vs mental illness)
- Off label prescribing (>50%)
- Under medicated for mental illness

  (e.g. Clozapine, ECT, Lithium), despite no evidence for exclusion

(Robertson et al 2000)

Specific Considerations in ID

Underlying brain abnormalities

Cognitive & functional impairment

Co-morbid physical health problems

Weight gain

Increased risk of interactions

Idiosyncratic responses

Knowledge of prescribed medication – patients and carers

Side Effects

Side effects may be undetected because:

- Functional disability masks toxicity
- Difficulties informing others
- Pre-existing stereotypic behaviours mask drug-induced abnormal movements
- Distinguishing between adverse effects and co-morbid medical or psychiatric conditions

Indications for Prescribing

- **Psychotropic medication should be prescribed for:**
  - A therapeutic trial for a confirmed or suspected psychiatric disorder
  - Challenging behaviour under certain circumstances
- **The following behaviours may be targets of treatment in the context of a diagnosis or on their own:**
  - Self injury
  - Aggression / property damage
  - Impulsivity/hyperactivity
  - Social withdrawal
  - Excessive dependency
  - Non-compliance
- **Behavioral & environmental interventions first option**
- **Restrictive intervention - Disability Act Vic 2006**
- **Be aware that prescribing psychotropic medications for NDIS participants can be considered restrictive practice, and therefore must be clearly justified.**

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Medications

- Antipsychotics
- Antidepressants
- Mood Stabilisers
- Anxiolytics & Hypnotics
- Benzodiazepines

Good Prescribing

Be clear regarding:

1. Rationale for treatment (including measurement of baseline target behaviours), potential risk/benefit and consent.
2. Review impact of medication and adverse effects at each review
3. Drug interactions should always be considered, especially with anticonvulsants

Rating Scales & Instruments

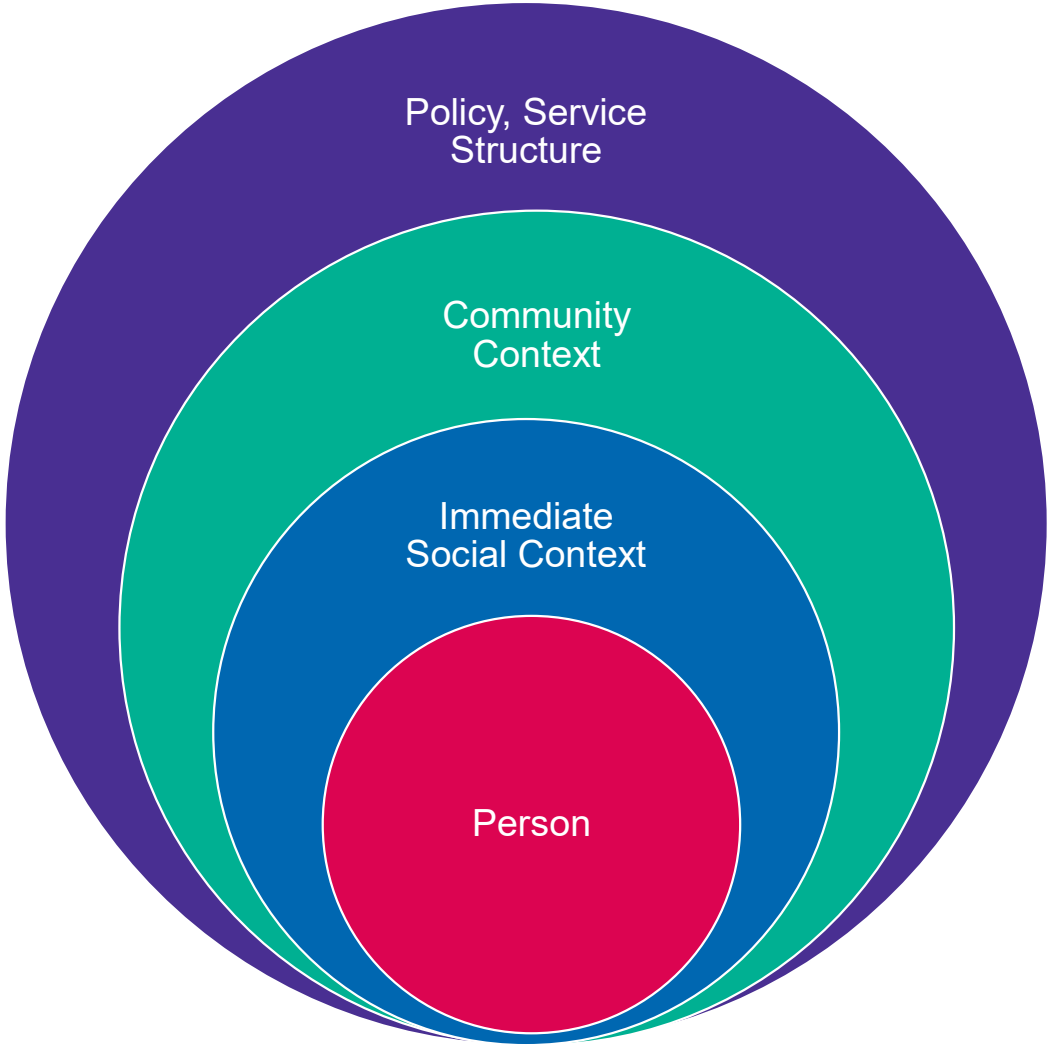
Can be helpful in ongoing assessment and management

Examples:

- Glasgow Depression Scale
- Abnormal Involuntary Movement Scale

Psycho-social Interventions

Management and Interventions



Requirements for Psychological Therapy

- ✓Motivation
- ✓Ability to communicate
- ✓Ability to form relationship with the therapist
- ✓Psychologically minded (reflect, identify and link emotions, thoughts, behaviours with outcomes)
- ✓Realistic expectations (ability to consent)
- ✓ Ability to tolerate distress
- ✓ Good health (dental, epilepsy, genetic phenotypes)
- ✓ Stable housing, lifestyle and supports
- ✓ Stable mental state/low risk
- ✓ Sensory differences, mobility, continence issues

Selecting an Appropriate Therapy

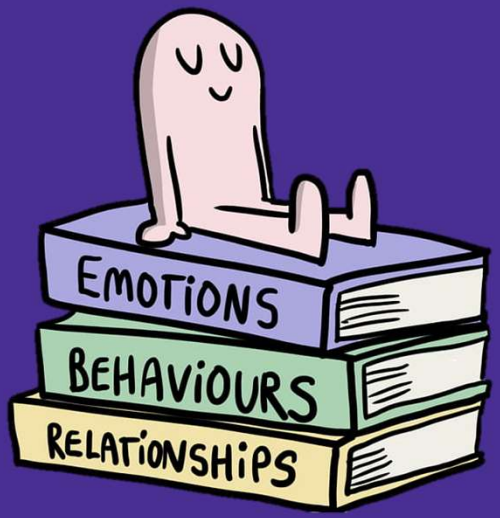
- Indications are the same as for those without ID
- Depends on diagnosis, preferences & available support
- Consider the individual's unique abilities & support needs
- Complexity, likely duration of therapy
- Goals and evaluation
- Additional considerations & modifications

Psychosocial Interventions

- Applied Behaviour Analysis/Positive Behaviour Support (ABA/PBS)
- Cognitive Behavioural Therapy (CBT)
- Dialectical Behaviour Therapy (DBT)
- Grief Therapy / Counselling
- Supportive Psychotherapy
- Trauma-based Approaches
- Motivational Interviewing
- Psychoeducation (Adapted)
- Alternative Therapies (e.g. drama, music therapy, sensory integration)

Barriers to Psychological Therapy

- Motivation (often taken to therapy as someone else wants them to change)
- Navigating a route into health services / therapy
- Lack of clear pathways or protocols
- Services eligibility criteria & degree of flexibility
- Cost
- Availability of trained & experienced therapists
- Therapeutic nihilism

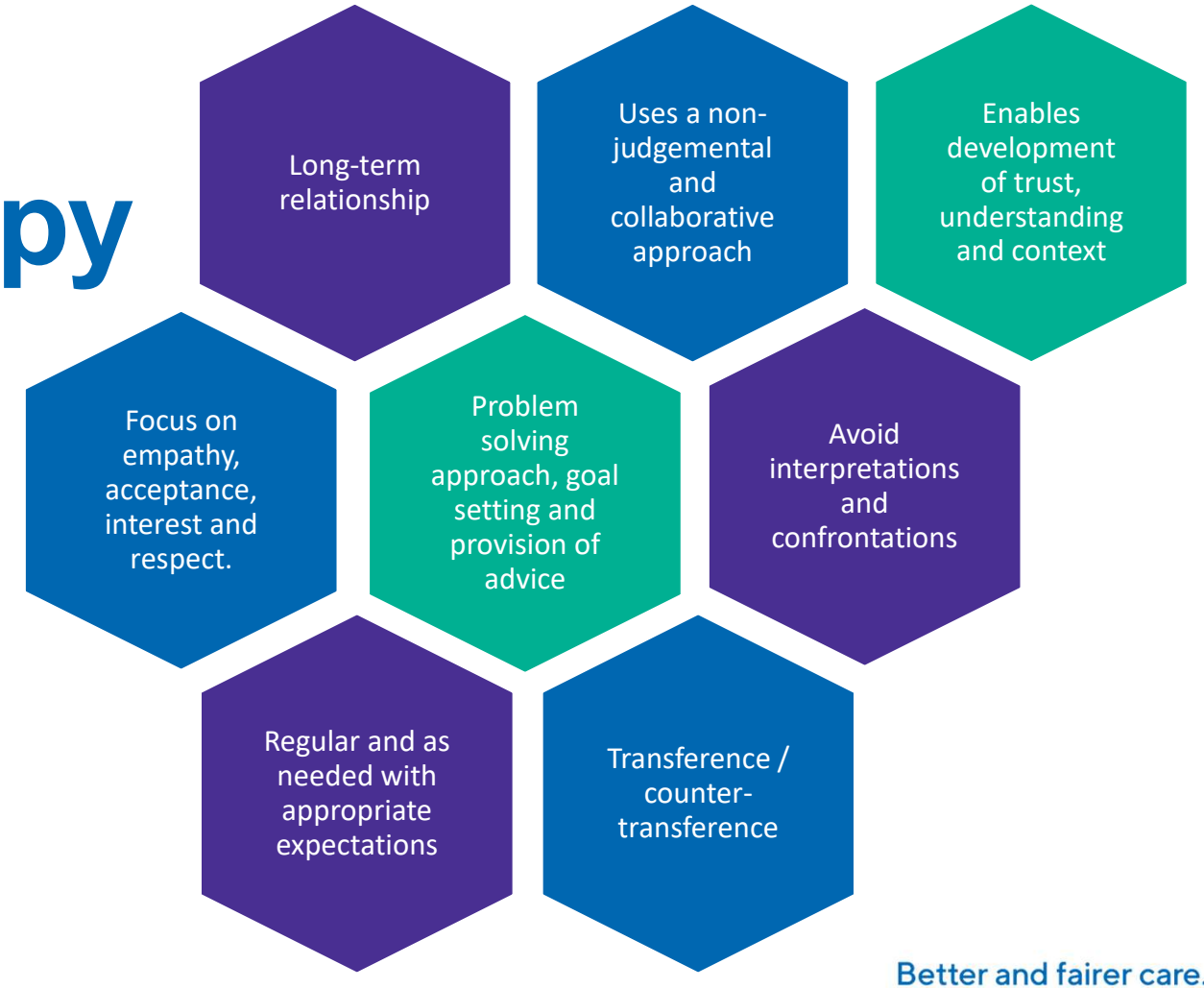


- May not fit standard treatment programs (psychoeducation, motivational interviewing, CBT, DBT, peer support groups) and may need ID specific groups
- Excessive compliance/desire to please
- Reduced capacity to respond to therapy (use of abstract concepts, to make cognitive links, to predict consequences, sequence, time frames)

Adaptation to Psychotherapy

Simplification (Concepts)	Language (concrete, less abstract)
Activities (Homework)	Developmental level (pictures, simple diagrams)
Directive methods	Flexible methods (role play)
Involve caregivers	Transference / Countertransference
Disability / rehabilitation approaches	Time frames

Supportive Psychotherapy



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Applied Behaviour Analysis (ABA)

- Long history in developmental disability
- Applicable to a range of mental & behaviour disorders
- ‘Scientific approach’
- Based on functional analysis, learning theory
- Comprehensive & systematic
- Considerable research especially in ASD
- Ethical concerns due to unfortunate history / misuse

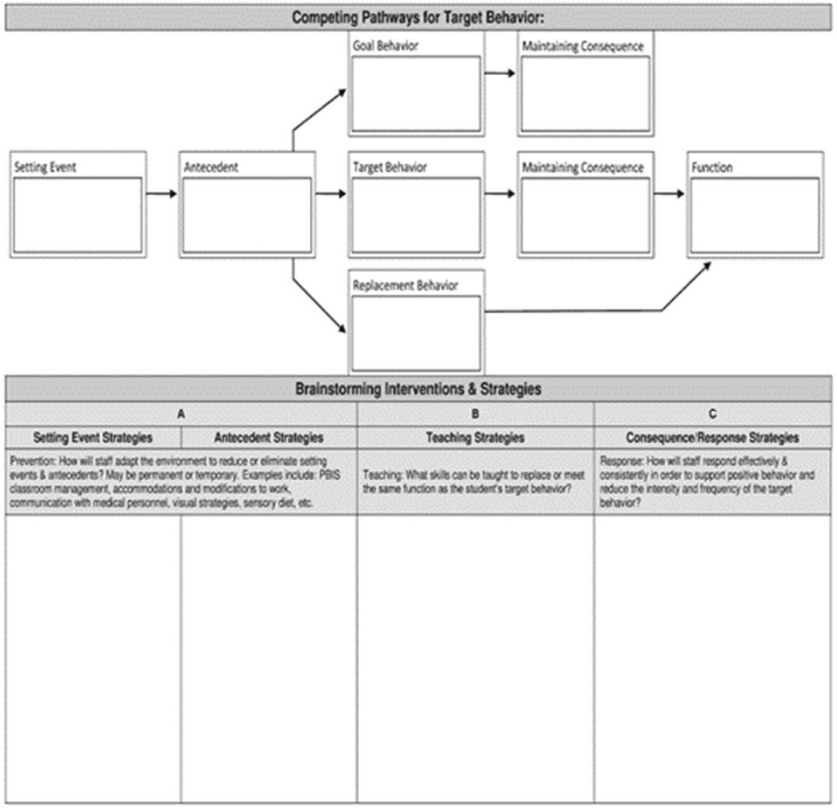
Positive Behaviour Support (PBS)

- Person-centred approach
- Aims to improve the quality of a person's life and that of the people around them
- Proactive & preventative, focusing on teaching new skills to replace behaviours that challenge
- Informed by functional behavior assessment, functional analysis
- Derived from behaviour theory and practice (Skinner)
- Good evidence of effectiveness

Positive Behaviour Support

Functional Behaviour Assessment (FBA)

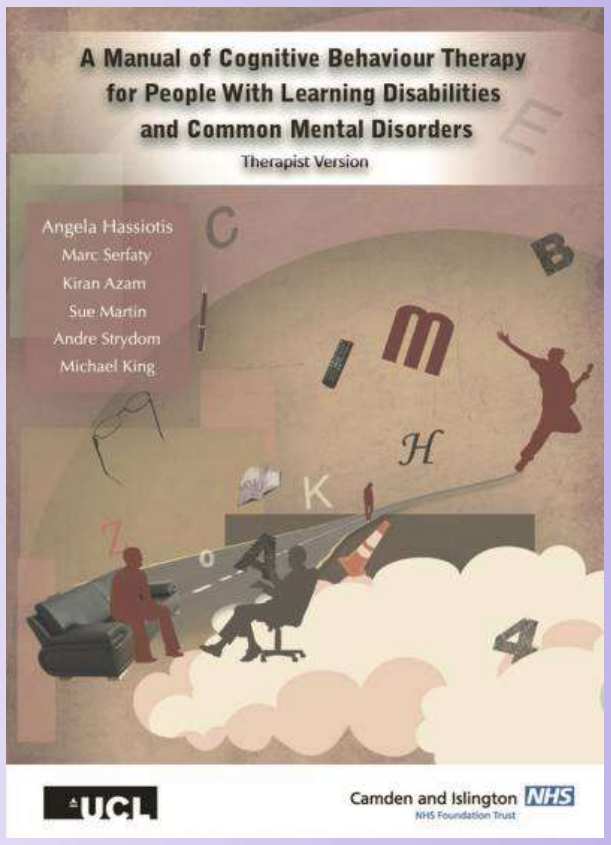
PROACTIVE STRATEGIES			REACTIVE STRATEGIES
Ecological Manipulation	**Positive Programming**	**Direct Treatment**	
• Settings • Interactions • Instructional Methods • Instructional Goals • Environmental Pollutants (e.g., noise, crowding) • Number and Characteristics of other people	• General Skills • Development • Functional equivalent • Functional related • Coping/ Tolerance	*Behavioral* • Differential Schedules of Reinforcement • Stimulus Control • Instructional Control • Stimulus Satiation • Etc. *Other* • Neurophysical Techniques • Medication Adjustments • Dietary Changes • Etc.	• Active Listening • Stimulus Change • Crisis Intervention

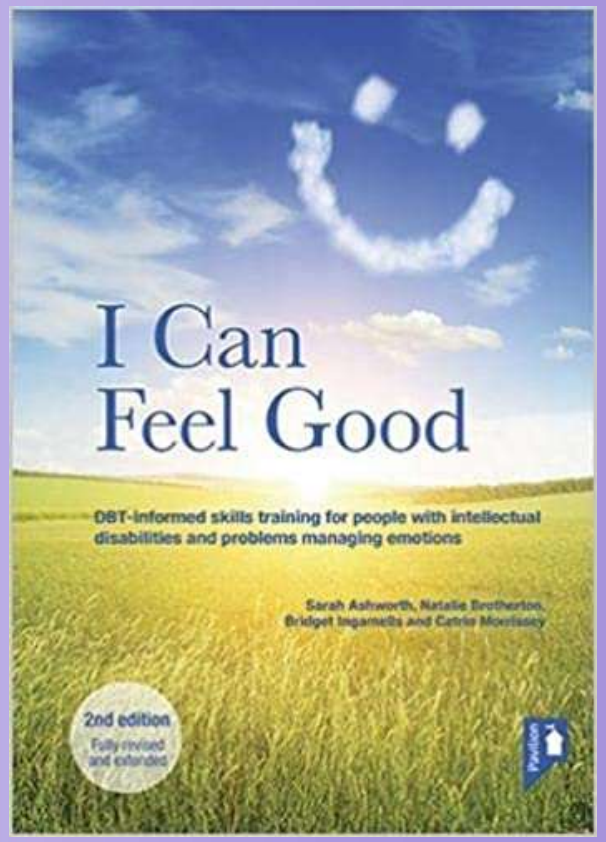


Inappropriate and Punitive Strategies

- Reactive strategies alone
- Physical interventions
- Seclusion
- Negative reinforcement/ Punishment / Aversion
- With-holding positive activities
- Time out

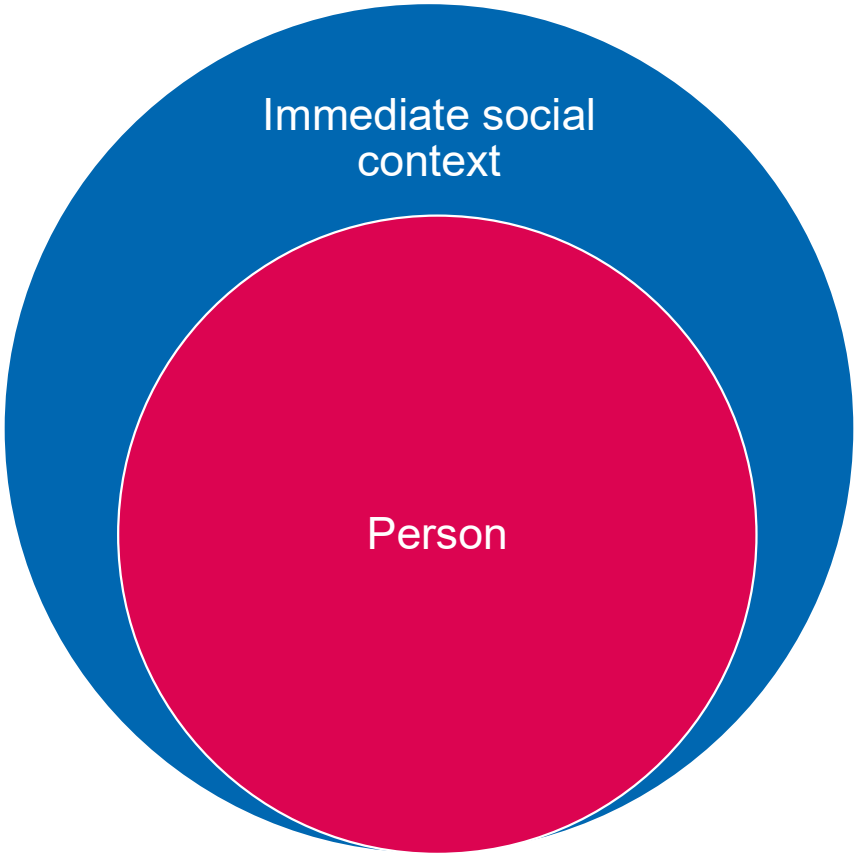
Useful Resources





https://www.ucl.ac.uk/psychiatry/research/epidemiology-and-applied-clinical-research-depa/principal-investigators/hassiotis-5

Psychosocial Interventions: Social Context



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Immediate Social Context

- Accommodation (stability, familiarity, facilities, décor, location)
  - Family home, shared supported accommodation, SRS, Motel
- Co-residents, carers/family, alone
- Level of support required (personal, domestic, community)
- Amount of supervision/containment (risk management)
- Diet, sleep, exercise, sensory needs (lighting, noise)
- House rules (TV, domestic tasks, smoking, drugs, sex, guests)

Immediate Social Context

- **Family:**
  - Degree of involvement varies, often complex
  - Default guardian
  - Difficult to change longstanding patterns of interaction
  - Unregulated (restrictive practices)

- **Paid carers:**
  - Often transient,
  - Variable support, training, skills & experience
  - Lack knowledge of mental disorders
  - 'Fit' with client (age, gender, demographics, personality)
  - Care may involve intimate physical contact (abuse, neglect, dependency)

Immediate Social Context

- **Family and carers interventions**

➢ Education = increase in knowledge (mental disorders/ disability/treatment/supports/services)

➢ Training = increase in skills

➢ Behaviour intervention

➢ Specific interventions e.g. EE

➢ Administration of medication (PRN)

➢ Supporting psychological therapies

➢ Risk management (restraint, seclusion, monitoring, preventing access)

➢ Advocacy (parents and carers often important advocates)

Immediate Social Context

- **Co-residents/Friendships/Relationships**

➢Mix of residents (ability, gender, mobility)

➢Safety of person / others

➢Issues of capacity (sexual relationships)

➢Opportunity (venues, travel, sleepovers)

➢Routine, predictability

Psychosocial Interventions

Community Context

Occupation, recreation, leisure (boredom)

Finances and supports (ability to choose clothing, décor, holidays, food)

Availability of Community facilities (shops, facilities, sports, specific interests, GP, dentist)

Access to community facilities (public transport, sensory issues, communication issues, risk issues)

Sense of belonging, participation, self efficacy

Stigma, exclusion, bullying, abuse

Risk to self/others

Psychosocial Interventions

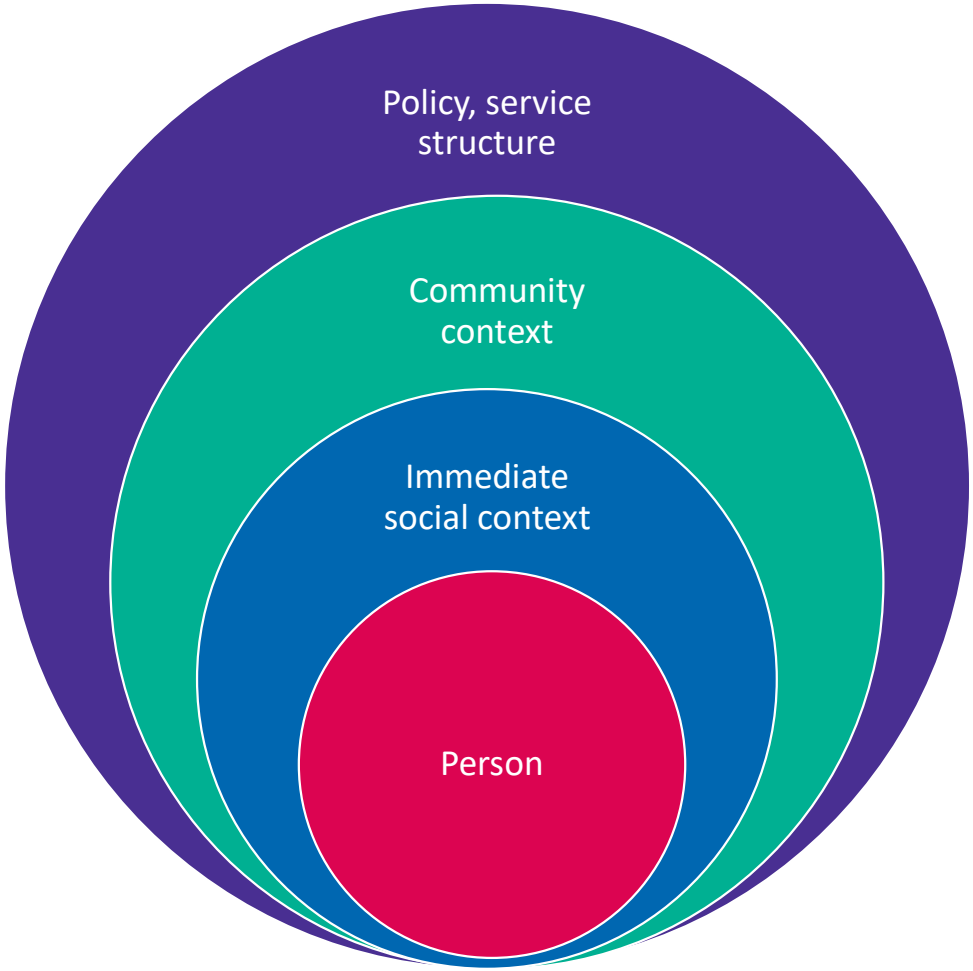
Interventions should:

- Person-centred approach
- Increase long-term relationships and social supports
- Create opportunities, be creative, cost and transport
- Build practical and social skills
- Increase psychological resilience (trauma prevention)
- Increase social inclusion
- Consider role of support staff

Lifestyle / Social Interventions

Benefits	Barriers
Build resilience through improved coping skills.	Need support
Improve confidence and self-esteem	Money / Cost
Improve physical health and social wellbeing	Communication differences
Improve quality of life	Limited community resources
Reduce symptoms and impact of mental disorders	Stigma
Sustainable	Accessibility (transport)

Psychosocial Interventions

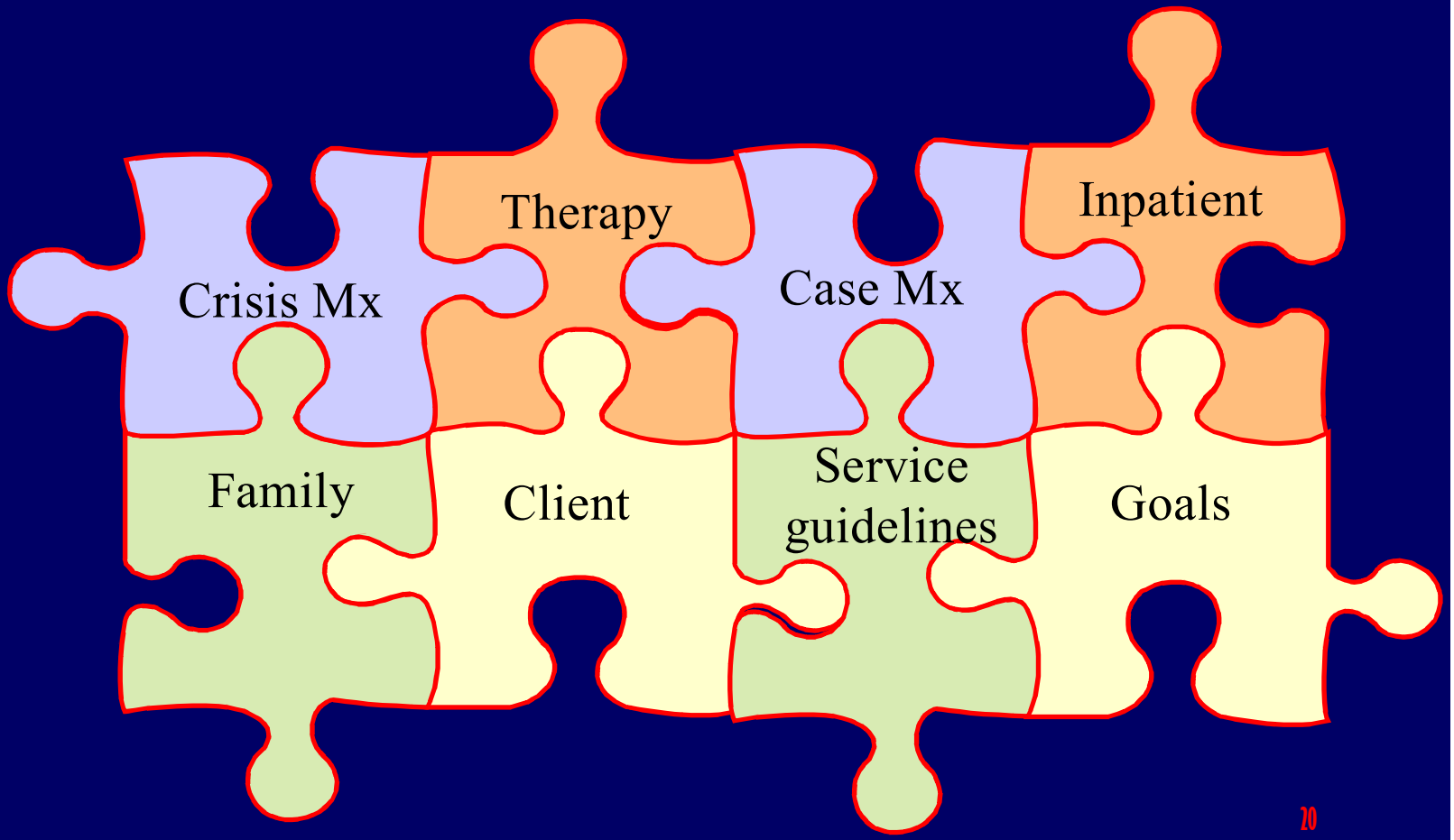


Policy

- **? Most important as determines funding, service structure and delivery**
  - Inpatient units
  - Medical screening
  - Staff training
  - Role of services
  - Data collection

- **All policy should consider impact on people with ID**
  - ? Recovery model
  - ? Consumer participation
  - ? Mental Health and Wellbeing Act

Putting the pieces together



Summary

- People with ID are at increased risk of mental disorders
- Experience difficulty accessing adequate mental health care
- Require additional supports & more time
- Require ‘reasonable adjustments’ to usual management

Thank you

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