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
Objectives

- 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
* 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
Disparities

ID magnifies race/ethnicity disparities

Institutionalization
Rights not respected (more so with Hispanic and African Americans)

Socioeconomic disadvantage

Less likely to receive preventive health care (family income a bigger predictor)

Diagnosing difference (White people more likely to be diagnosed with mild ID versus African American and Hispanic people)

NCI data (NASDDDS)
Severity

- Borderline
- Mild
- Moderate
- Severe
- Profound

Causes

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

- Intellectual Disabilities
- Communication Disorders
- Autism Spectrum Disorder
- Attention Deficit Hyperactivity Disorder
- Specific Learning Disorders
- Motor Disorders
- Tic Disorders

*Distinctions*
Screening, signs and symptoms
Diagnosing

* Diagnosing Psychiatric Comorbidities
**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

- Caregiver opinions
- Overly complex questions
- Generalizations

Use

- 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
Antecedant

Behavior

Consequence

*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
Coordination

- Individual
- Family
- Specialists
- Group home/supports
- Primary Care Provider
- Regional Center
- Programs
Great Resources:
Diagnostic Manual for Intellectual Disabilities (DM-ID)
Schreiber Center
Thank you

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