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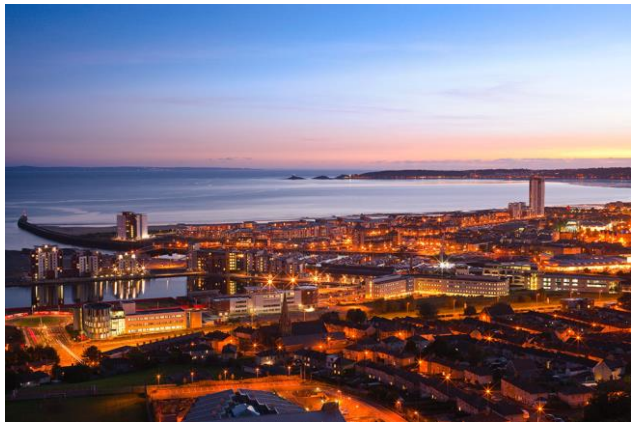

Mental health and intellectual disability – holistic client centred mental healthcare

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Aim of talk

TO ANSWER AS MANY OF YOUR QUESTIONS AS I CAN

The nature of mental health problems in people with an intellectual disability

Psychiatric illness/poor mental health does occur – and its quite common

Mental Health-including challenging behaviour in the population of people with an intellectual disability

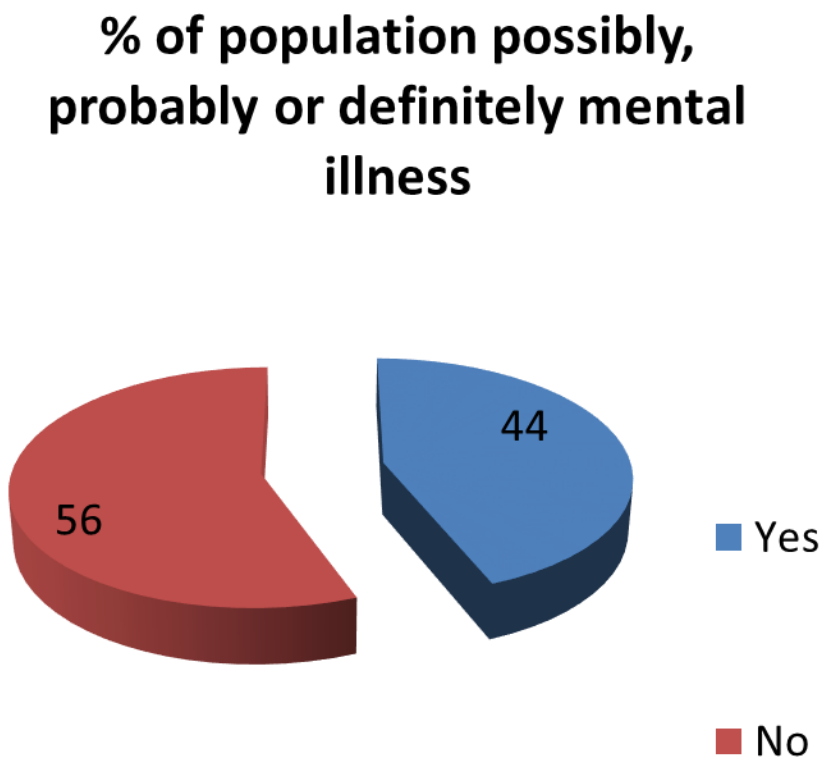
Population based study of 1023 adults with a learning disability

Service derived population through social services

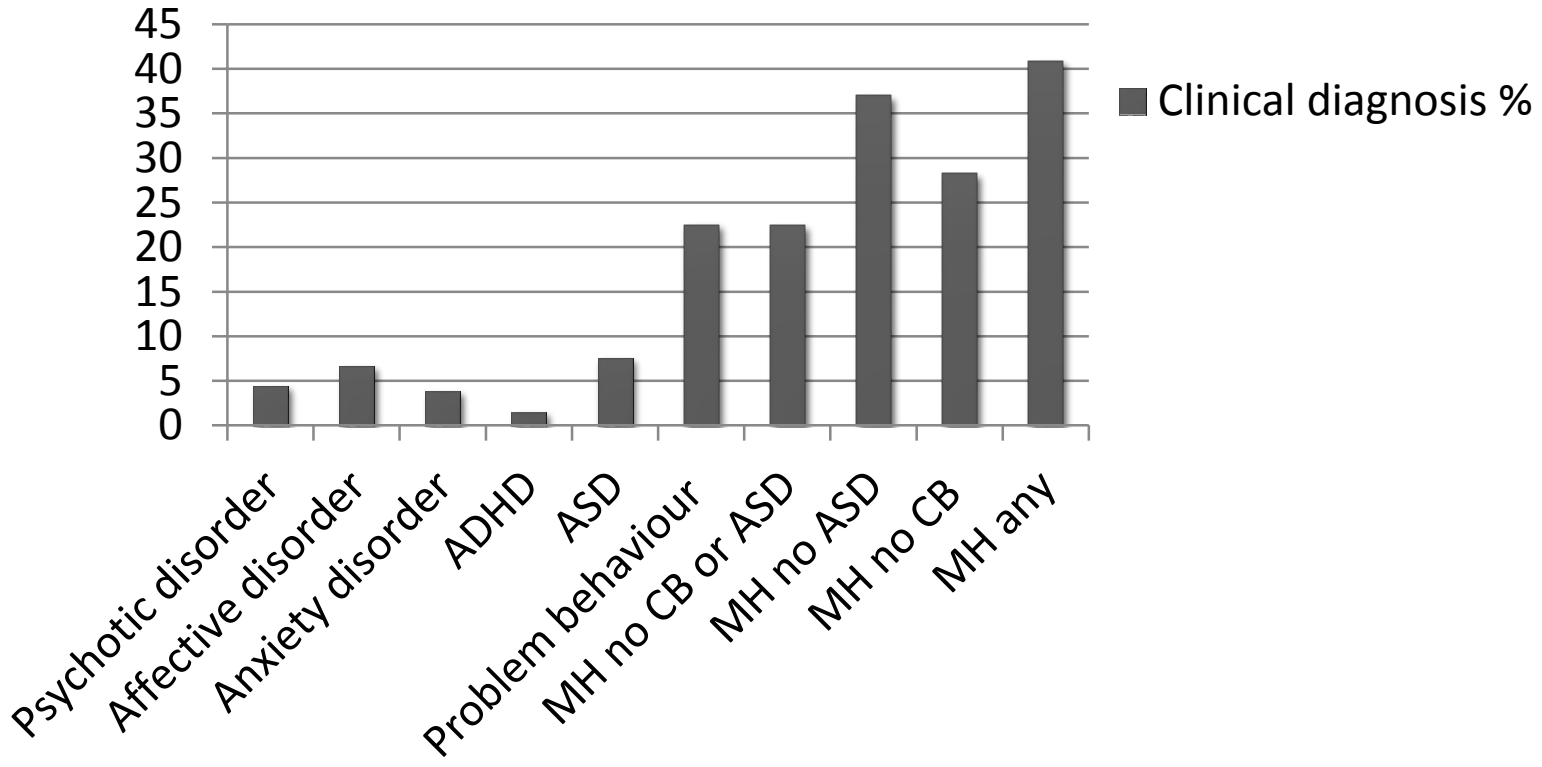
Initial screening by specialist nurse then psychiatric assessment

PAS-ADD Checklist plus Vineland and full psychiatric assessment

* Cooper et al B.J.Psych (2007), 190, 27-35.



How common is mental illness at one point in time in a group of people with intellectual disability?



Diagnosing mental health disorder in people with an intellectual disability

LOTS OF SCALES

CLINICAL SKILL

Task one

GROUP 1

Name 10 symptoms of depression in a person with an intellectual disability

GROUP 2

Name 10 symptoms of depression in a person who does not have an intellectual disability

Affective

DEPRESSIVE

Depressive

Guilty

Hypochondriacal

nihilistic,

self-referential

persecutory

MANIA

The mood is elevated or irritable to a degree that is definitely abnormal for the individual concerned and sustained for at least four consecutive days.

increased activity or physical restlessness;

increased talkativeness;

difficulty in concentration or distractibility;

decreased need for sleep;

increased sexual energy;

mild spending sprees, or other types of reckless or irresponsible behaviour;

increased sociability or over-familiarity.

What is depression – 10 symptoms?

persistent sadness or low mood; and/or:

loss of interests or pleasure

fatigue or low energy

at least one of these, most days, most of the time for at least 2 weeks

if any present, ask about associated symptoms:

disturbed sleep

poor concentration or indecisiveness

low self-confidence

poor or increased appetite

suicidal thoughts or acts

agitation or slowing of movements

guilt or self-blame

Severity

Subthreshold (fewer than five symptoms)

Mild depression (five to six symptoms mild functional impairment)

Moderate depression (symptoms or functional impairment are between mild and severe)

Severe depression (Most symptoms, markedly impact on functioning and may or may not be psychotic)

symptoms should be present for a month or more and every symptom should be present for most of every day

Task two

GROUP 1

Name 10 symptoms of psychosis in a person with an intellectual disability

GROUP 2

Name 10 symptoms of psychosis in a person who does not have an intellectual disability

Schizophrenia* -

AT LEAST ONE OF:

Thought echo, thought insertion or withdrawal, or thought broadcasting.

Delusions of control, influence or passivity, clearly referred to body or limb movements or specific thoughts,

actions, or sensations; delusional perception.

Hallucinatory voices giving a running commentary on the patient's behaviour, or discussing him between themselves, or other types of hallucinatory voices coming from some part of the body.

Persistent delusions of other kinds that are culturally inappropriate and completely impossible (e.g. being able to control the weather, or being in communication with aliens from another world).

OR AT LEAST TWO OF:

Persistent hallucinations in any modality, when occurring every day for at least one month, when accompanied by delusions (which may be fleeting or half-formed) without clear affective content, or when accompanied by persistent over-valued ideas.

Neologisms, breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech.

Catatonic behaviour, such as excitement, posturing or waxy flexibility, negativism, mutism and stupor.

"Negative" symptoms such as marked apathy, paucity of speech, and blunting or incongruity of emotional responses (it must be clear that these are not due to depression or to neuroleptic medication).

*ICD 10

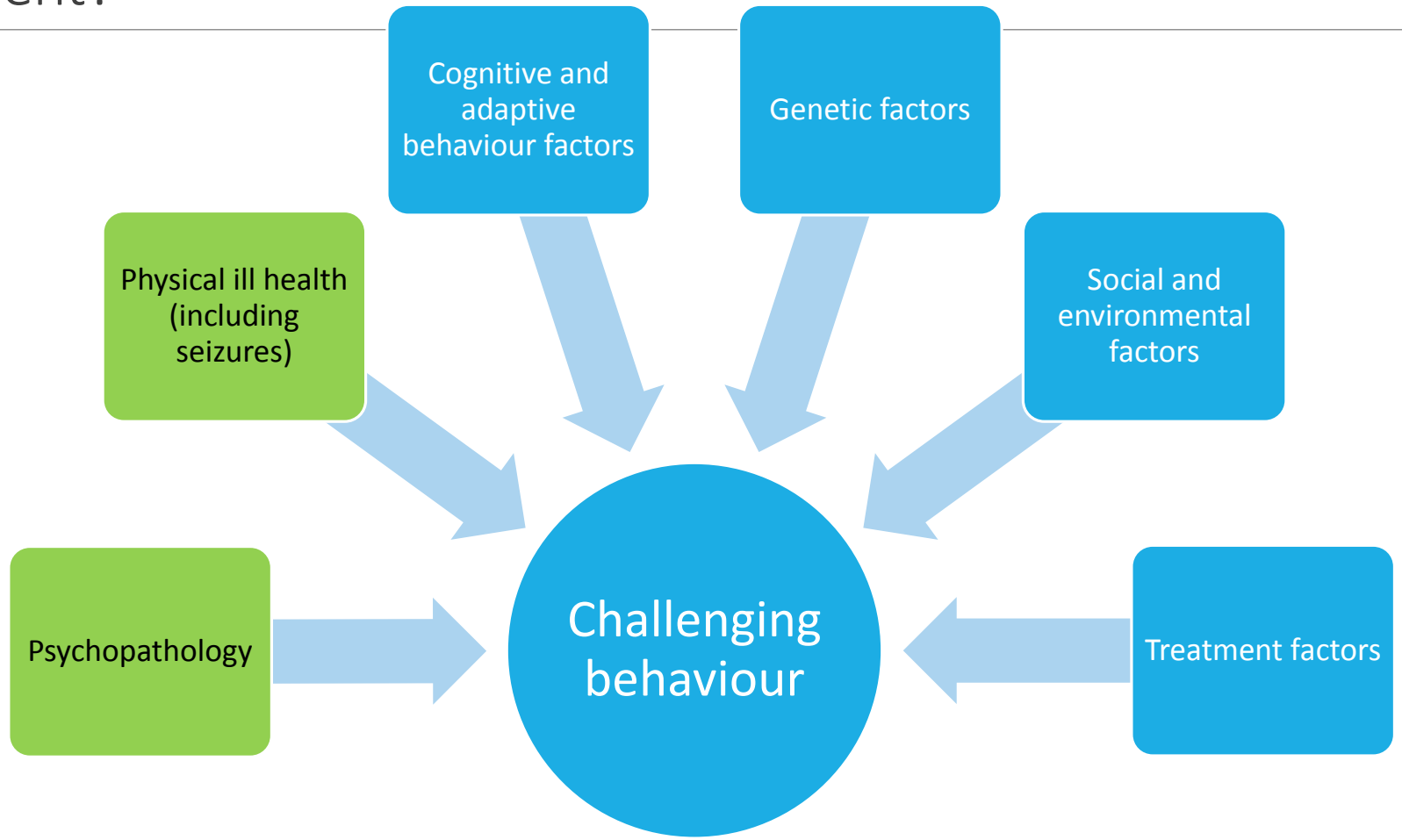
The Three I's


Identify the problem
Individualise the management plan
Implement the plan

Key question

What causes mental ill health and challenging behaviour in people with an intellectual disability?

How do we understand challenging behaviour in people with cognitive impairment?



Social and environmental factors: Life events*

SINGLE EVENTS

Bereavement

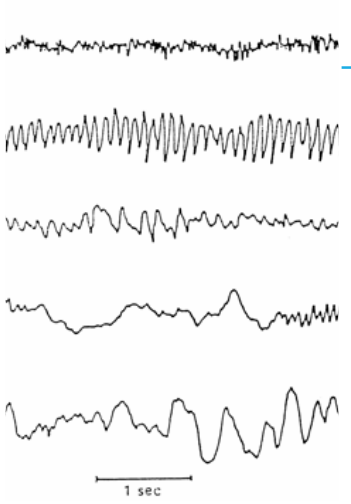
CUMULATIVE EVENTS

Cumulative events-individuals referred with behaviour disorder were 1.68 times more likely to have experienced life events in the previous 12 months.

Also associate with aggressive/destructive behaviour

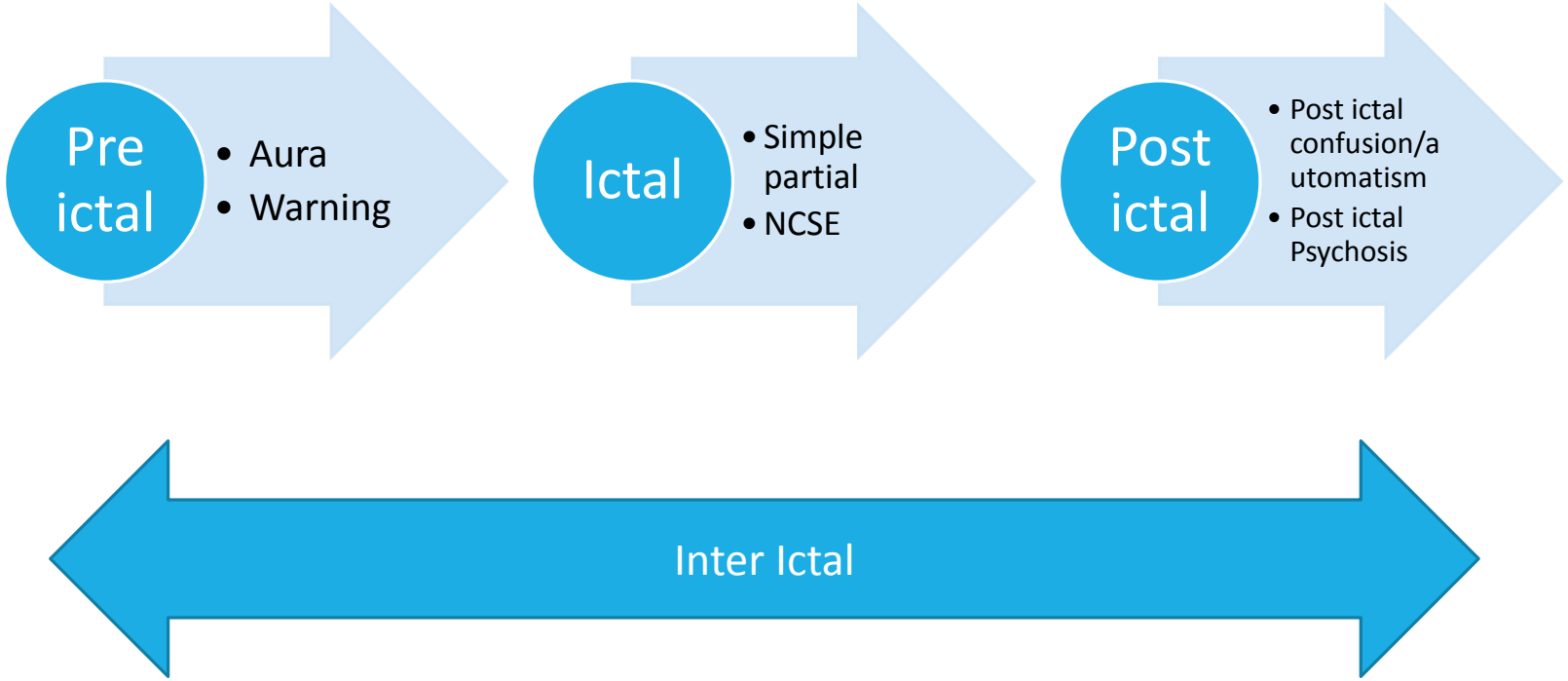
*Hulbert-Williams & Hastings. JIDR 52, 11, 888-895

Having other health problems- impact on mental health



Epilepsy

relationship with seizures

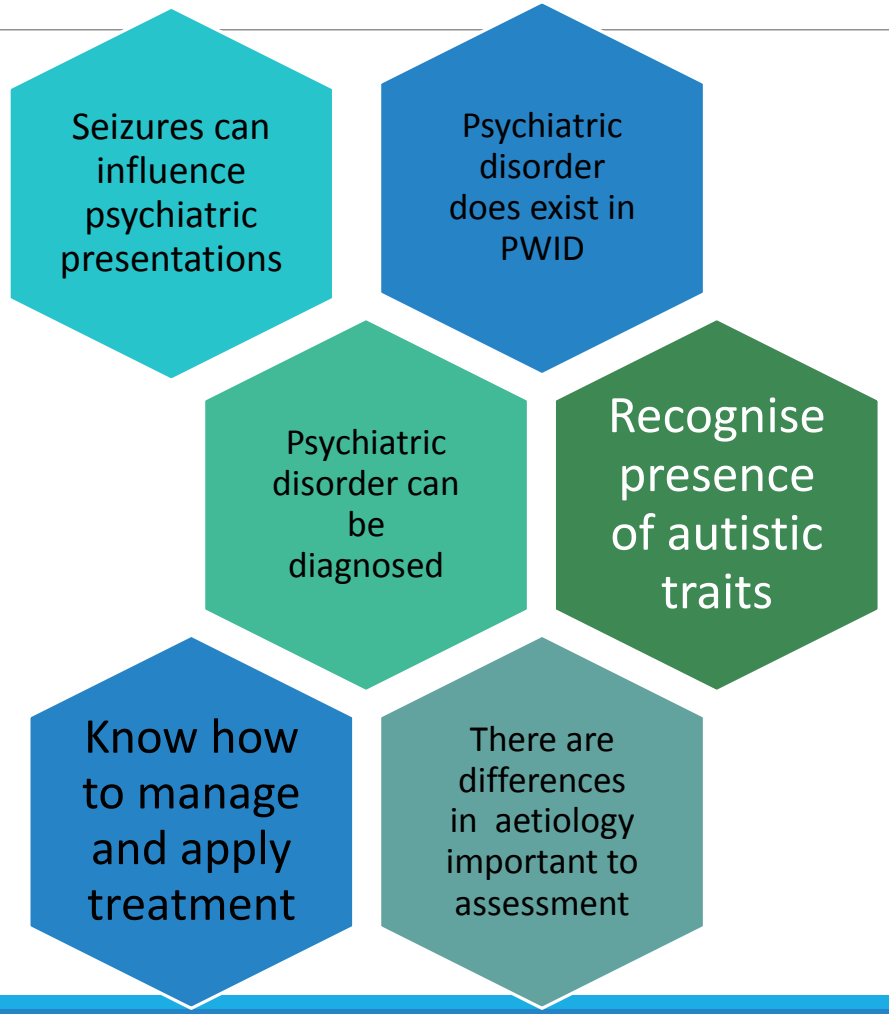


Management plans

TheThree I’s


Identify the problem
Individualise the management plan
Implement the plan

Clinical core knowledge set for professionals and services

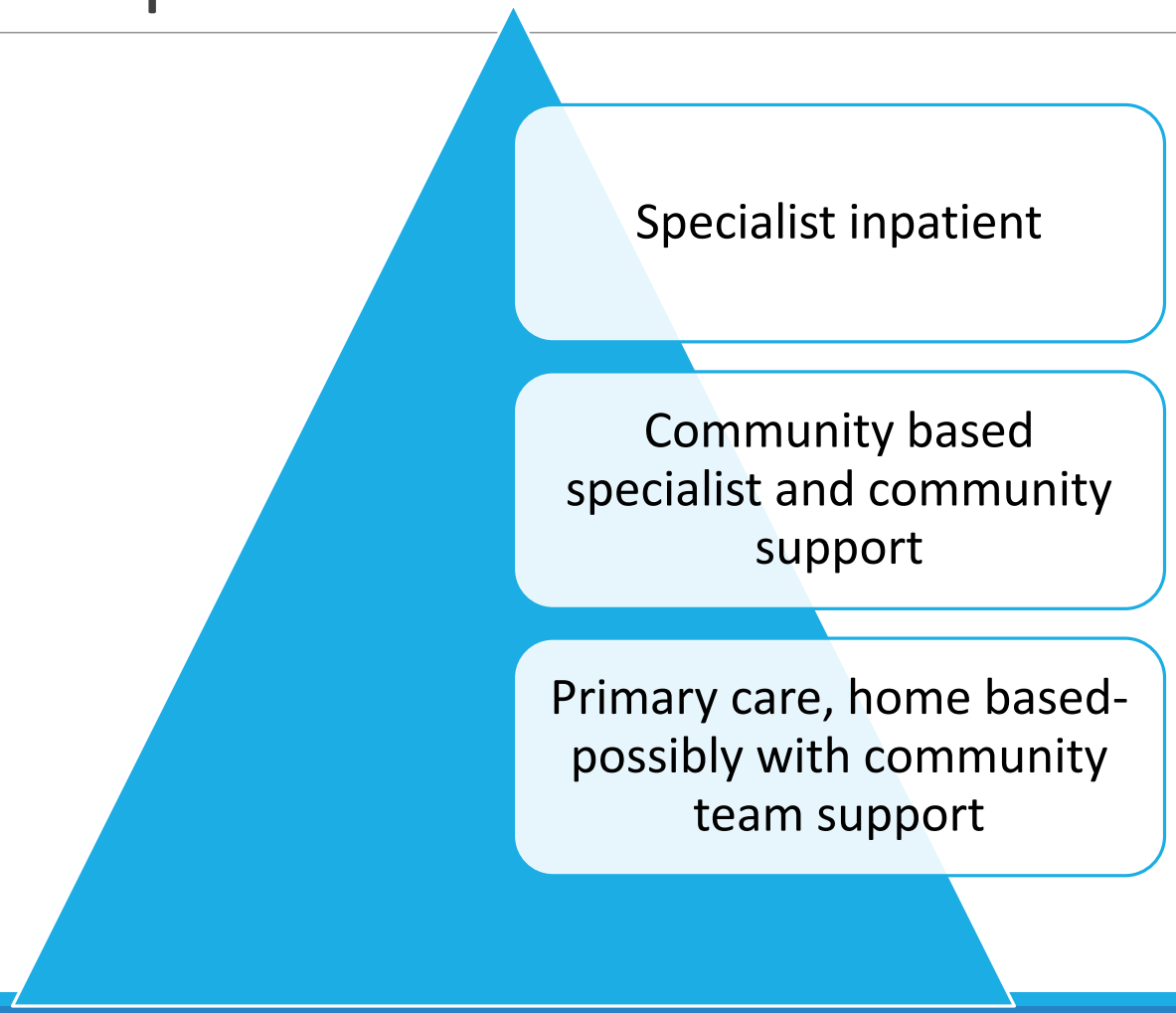


Know how to manage and apply treatment

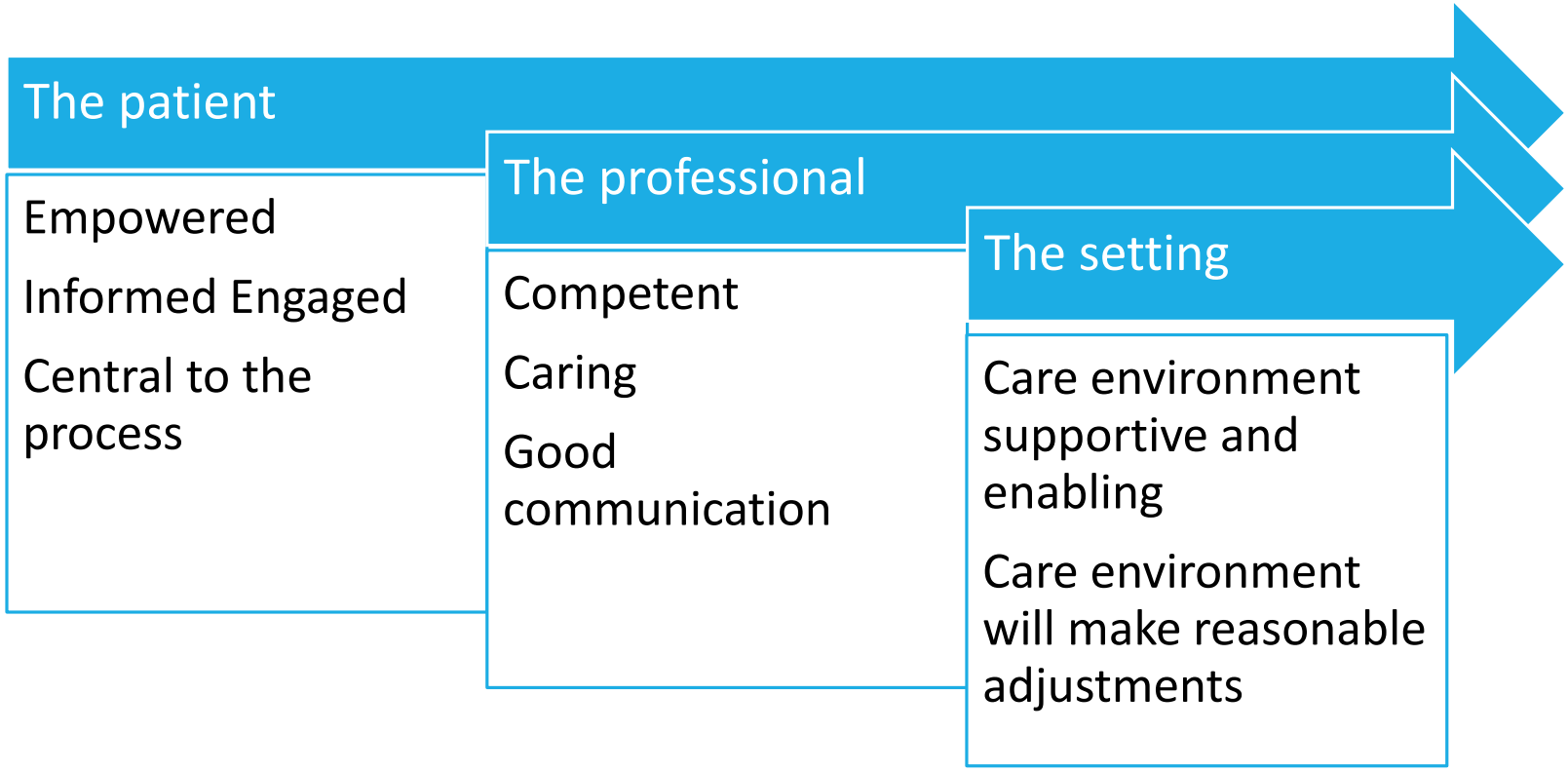
TREATMENT MODALITIES

TREATMENT RISK

The treatment setting: it has to be skilled and appropriate



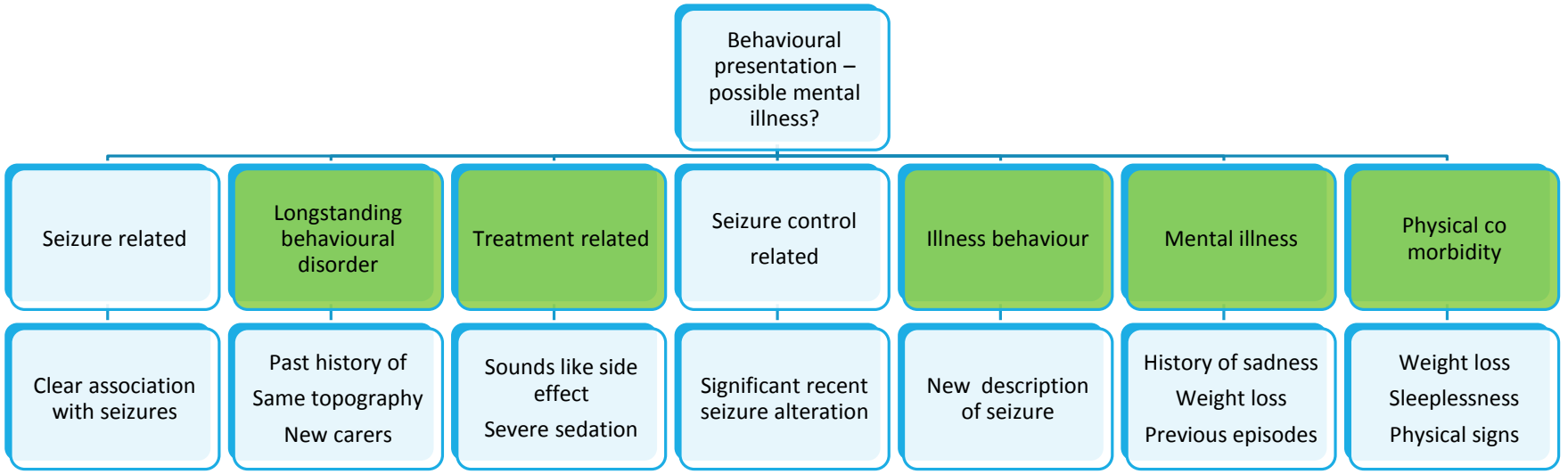
The treatment principles



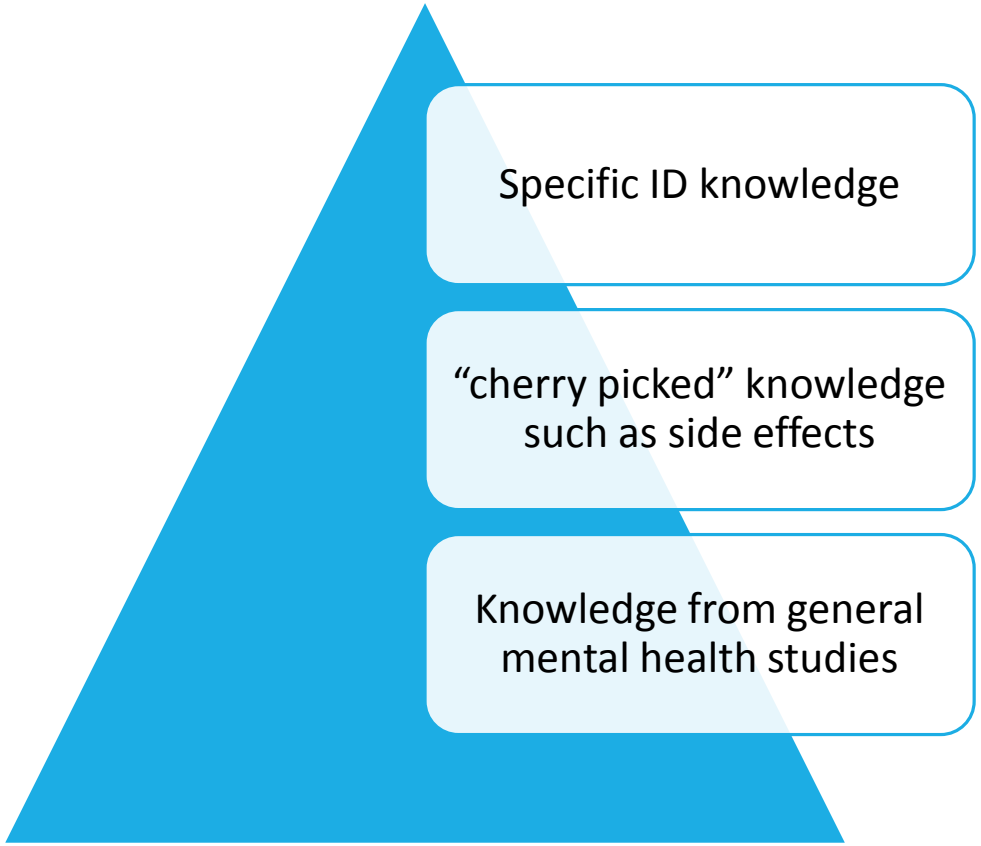
Treatment modalities for mental well being

Psychological	• CBT for anxiety • ABA
Pharmacotherapy	• Antidepressant for depression/anxiety • Antipsychotic for psychosis
Complex interventions	• Behaviour support teams • Behavioural activation

Assessing psychopathology



Psychotropic medication in people with an intellectual disability



"…..in the years to come, *PWID** may claim an all-time record, of having the greatest variety and the largest tonnage of chemical agents shovelled into them" and "If your aim is helping *PWID*, I urge you to avoid the casual clinical trial of drugs. Make them good trials, or don't make them at all".

Greiner (1958) (*my insertion)

"This is not restricted to drugs but too many activities that would be considered mundane and routine are labelled as therapuetic in PWID"

Kerr

REASONS FOR PSYCHOTROPIC PRESCRIPTION

Treatment of clearly diagnosed primary psychiatric illness.

Treatment of medical conditions, e.g. Epilepsy.

Sedation prior to stressful clinical procedures.

Treatment of withdrawal / discontinuation symptoms.

Severe dysfunctional behaviour resistant to other interventions.

Psychotropic medication for behaviour

LOTS AND LOTS OF GUIDANCE

INAPPROPRIATE USE

Psychotropic medication shall not be used excessively, as punishment, for staff convenience, as a substitute for meaningful psychosocial services, or in quantities that interfere with an individual's quality of life.

Using medication to manage behaviour problems among adults with a learning disability

Quick reference guide (QRG)

Shoumitro Deb, David Clarke and Gemma Unwin
University of Birmingham
www.LD-Medication.bham.ac.uk

September 2006

Standards for use of psychotropic medication

Assessment of the Target behaviour should be documented including:

A. Description of behaviour

B. Severity and Frequency

Assessment of Capacity to consent to treatment should be considered and documented

Standards for use of psychotropic medication

1. Dosage should be within maximum range of BNF

2. Reasons for higher dosage should be documented at least once every 12 months

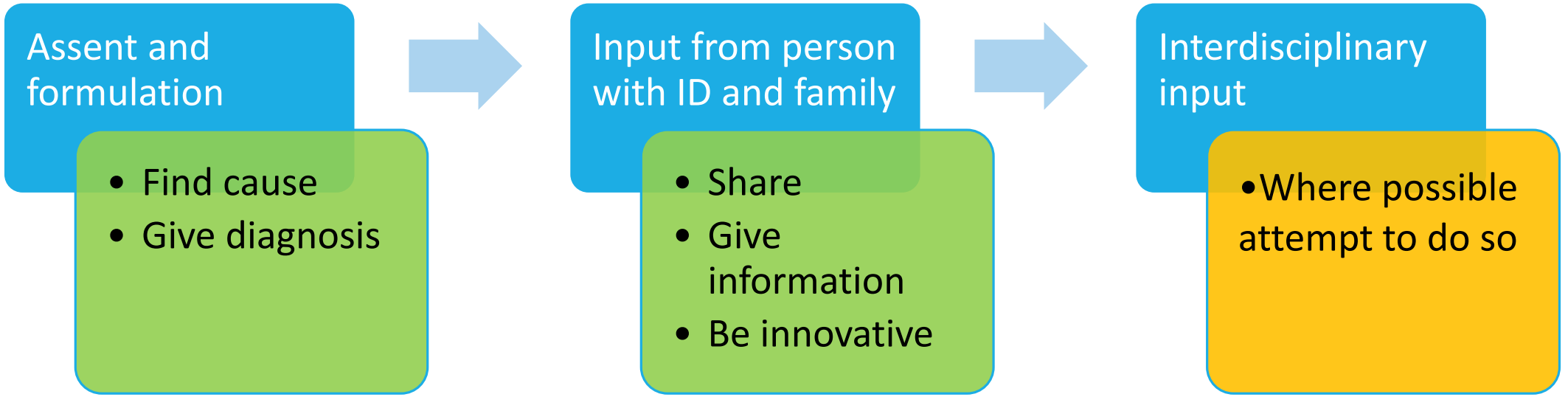
3. Drug side effects should be recorded and documented at least once every 12 months

4. Need for continuous prescription of antipsychotic drugs should be reviewed and documented at least once every 12 months

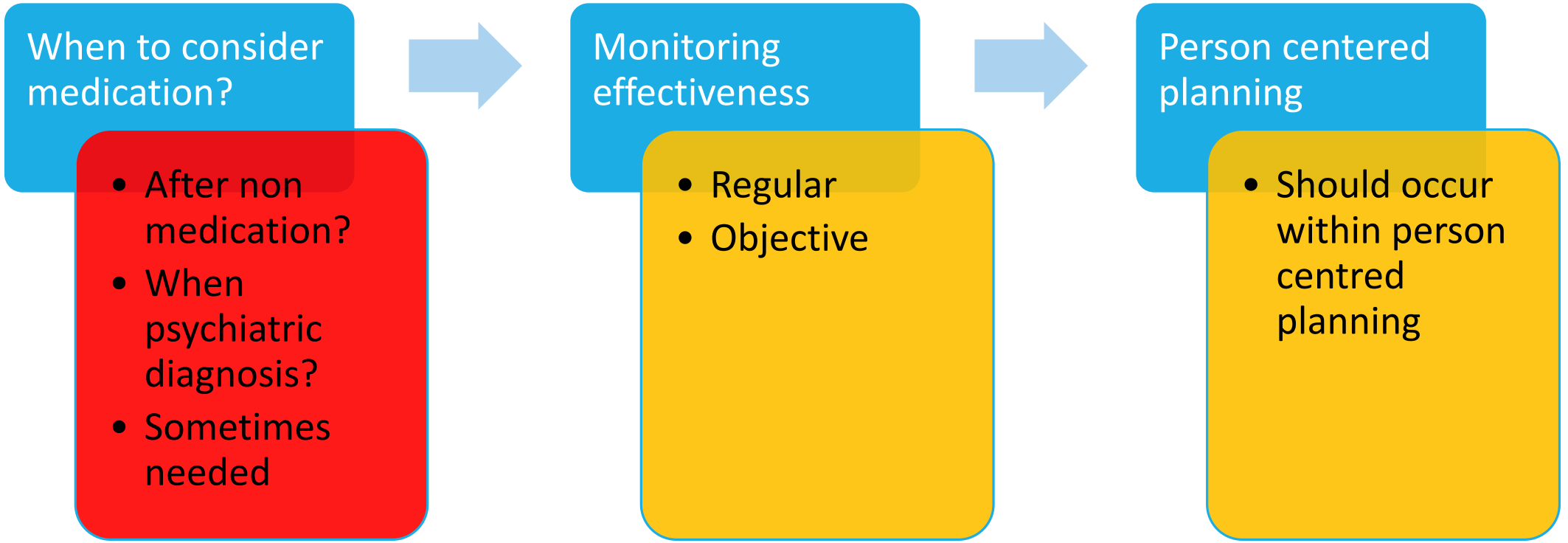
5. Consideration for other treatment options should be documented

6. Above BNF dosage should be reviewed every 3 months

General principles (1)



General Principles (2)



Drug treatment

1. When clear mental illness-such as depression treat appropriately

2 When no clear mental illness such as in challenging behaviour-evidence for medication working is not good. Ina person without capacity a very clear best interest decision is needed.

A carers plan