Mental Health 101

Supporting our client’s mental wellness

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San Gabriel/Pomona Regional Center
October 28th 2010
Outline of Presentation

• Concept of Dual Diagnosis
• Vulnerability Factors
• Best Practices in Assessment & Diagnosis
• Overview of the DM-ID
• Predictable Crisis & Prevention/Intervention
• Review of Mental Health Professionals
• Overview of types of Mental Health Services
CONCEPT OF DUAL DIAGNOSIS
Concept Of Dual Diagnosis

• Co-Existence of Two Disabilities: Intellectual Disability and Mental Illness

• Both Intellectual Disability and Mental Health disorders should be assessed and diagnosed

• All needed treatments and supports should be available, effective and accessible
Diagnostic Criteria Of Intellectual Disability

A. Significant sub-average intellectual functioning
   1. IQ of 70 or below

B. Concurrent deficits in adaptive functioning

C. The onset before age 18 years
What Is Mental Illness?

- Severe disturbance of:
  - thought
  - mood
  - behavior
  - and/or
  - social
  - and
  - interpersonal
  - relationships

- Common Disorders
  - Anxiety Disorders
  - Mood Disorders
  - Psychotic Disorders
  - Pervasive Disorders
Definition Of Mental Illness In Persons With Intellectual Disability

When behavior is abnormal by virtue of quantitative or qualitative differences

When behavior cannot be explained on the basis of development delay alone

When behavior causes significant impairment in functioning

Adapted from Enfield and Aman 1995
| **ID:** | refers to sub-average (IQ) |
| **MI:** | has nothing to do with IQ |
| **ID:** | incidence: 1-2% of general population |
| **MI:** | incidence: 16-20% of general population |
| **ID:** | present at birth or occurs before age 18 |
| **MI:** | may have its onset at any age (usually late adolescent) |
A Summary Of Similarities And Differences Between Intellectual Disability (ID) & Mental Illness (MI)

**ID:** intellectual impairment is permanent

**MI:** often temporary and may be reversible and is often cyclic

**ID:** a person can usually be expected to behave rationally at his or her developmental level

**MI:** a person may vacillate between normal and irrational behavior, displaying degrees of each

**ID:** adjustment difficulties are secondary to ID

**MI:** adjustment difficulties are secondary to psychopathology
Prevalence of MI in ID

33% of People with ID have co-occurring MI (NADD, 2005)
VULNERABILITY FACTORS FOR DEVELOPING PSYCHIATRIC DISORDERS IN PERSONS WITH ID
Vulnerability Factors for Mental Illness in Mentally Retarded Persons

- Incidence of Central Nervous System Impairment
- Reaction by Parents
- Effects of School
- Impaired Coping Skills
- Lack of Support Structure
- Feelings of Defeat & Failure
Vulnerability Exposure to Stress

- Greater exposure to negative life events
- Peer rejection (Philips)
- Residential transfers (Berkson, Heller)
- Negative self-image (Edgerton)
- Transition (Rusch & Chadsey-Rusch)
- Sexual abuse (Ryan)
- Communication of needs (Carr)
- Social Strain (Lunsky)
Vulnerability Exposure to Stress

**Bio**
- Physical Illness
- Genetics
- Vision/learning
- Meds

**Psycho**
- Life works
- Social/emotional vulnerabilities
- Self-acceptance/esteem
- Rejection
- Abuse

**Social**
- Inappropriate environments
- Stigma/social exclusion
- Supports to/network
- Social Relationships

Fletcher, 2010
BEST PRACTICES
IN
ASSESSMENT AND DIAGNOSTIC PROCEDURES
Best Practice Assessment: Bio-psychosocial Model
Best Practice Assessment: Bio-psychosocial Model

1. Review Reports
2. Interview Family
3. Interview Care Provider
4. Direct Observation
5. Clinical Interview
Mental Health Interview

I. Source of Information
II. Reason for Referral
III. History of Presenting Problem
IV. Past Psychiatric History
V. Family Health History
VI. Social/Developmental History
Minimal Data Collection

- Physical Health
- 24 Hours Sleep Chart (month cycle)
- Medication Changes
- Eating Patterns
- Environmental Changes
- Mood Charting
  - Symptoms and Behavioral manifestations
24-Hour Framework

Sleep Patterns
Eating Patterns
Mood Patterns
I. General Appearance and Behavior
II. Mood and Affect
III. Psychomotor Activity and Speech
IV. Thought Process and Content
V. Cognitive Functions
VI. Judgment and Insight
Multi-Axial Diagnoses

<table>
<thead>
<tr>
<th>Axis</th>
<th>Description</th>
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</table>
| **Axis I** | Clinical Disorders  
Other conditions that may be a focus of clinical attention |
| **Axis II** | Personality Disorders  
Intellectual Disability |
| **Axis III** | General Medical Conditions influencing diagnosis, treatment, or prognosis of Axis I or II disorders |
| **Axis IV** | Psychosocial an Environmental Problems, I.e., problems with primary support group, problems related to the social environment, educational problems, occupational problems, housing problems, economic problems, problems with access to health care services, problems related to interaction with the legal system/crime, other |
| **Axis V** | Global Assessment of Functioning  
This scale is for reporting the clinician(s) judgment of the individual’s overall level of functioning. This information is useful in planning treatment and measuring its impact and in predicting outcome. The scale ranges from “0” – inadequate information to “100” – no symptoms and superior functioning in a wide range of areas. |
1. Persons with Intellectual Disabilities suffer from the full range of psychiatric disorders

2. Psychiatric disorders usually present as maladaptive behavior

3. The origin of psychopathology is multi-determined

Adapted from Sovner 1989
Eight Diagnostic Principles For Recognizing Psychiatric Disorders In Persons With ID (continued)

4. An acute psychiatric disorder may present as an exaggeration of longstanding maladaptive behavior

5. Maladaptive behavior rarely occurs alone

6. The severity of the problem is not necessarily relevant diagnostically

Adapted from Sovner 1989
7. The clinical interview alone is rarely diagnostic

8. It is very difficult to diagnose psychotic disorders in persons with very limited verbal skills
Possible Signs & Symptoms Of Mental Illness

• Change in Sleep Patterns/Sleep Disturbance
• Overall Energy Level
• Mood and Affect
• Changes in Self-Care
• Isolation
• Physical Complaints
Possible Signs & Symptoms Of Mental Illness

• Loss of skills (Regression)
  • Change in Bowel or Bladder Function

• Loss of interest in preferred things (Anhedonia)

• Change in attention and concentration
Possible Signs & Symptoms Of Mental Illness

• Autonomic Symptoms (Subjective and Objective)
  • Sweating
  • Reports of Palpitations
  • Nausea
  • Dilated Pupils

• Response to Stressful Situation
  • Withdrawal
  • Hyper-vigilance
  • Agitation
Possible Signs & Symptoms Of Mental Illness

• Fear, Anxious Excessive Worry
• Hallucination and Delusions
• Restlessness
• Aggression
• Self-Abuse
• Property Destrucions
Increased Likelihood Of Mental Illness

- Symptoms/behaviors present themselves in all setting
- Symptoms persist despite consistent appropriate behavior intervention
- Sleep, appetite, or sexual behaviors are affected
- Change in behavior or symptoms, especially when abrupt and lasts more than a month
Conceptual Framework

- Develop a bio-psychosocial Approach
- Examine medical co-morbidity
- Brain chemistry is sensitive to stress
- Attempt to understand how the person experiences the World
- Create a hypothesis
DEPRESSION
Depression

• Psychiatric disorder that affects mind, body, and feelings

• May begin suddenly (triggered by loss or crises); can continue for months or years

• Single episode or multiple episodes (more common)

• Often unidentified and untreated
Depression

- Can significantly disrupt school, work, family relationships, social life, etc.

- Onset tends to be more insidious and changes less dramatic (Deb et al., 2001)

- Increased prevalence in some symptoms as compared to typical population (Matson, 1988)

- Depression is among the most common psychiatric disorders in persons with ID (Lamon & Reiss, 1987)
<table>
<thead>
<tr>
<th>DSM-IV-TR Symptom for Depression</th>
<th>Presentation in Someone with ID</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depressed Mood</strong></td>
<td>• Frequent unexplained crying</td>
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<tr>
<td></td>
<td>• Decrease in laughter and smiling</td>
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<td>• General irritability and subsequent aggression or self-injury</td>
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<td></td>
<td>• Sad facial expression</td>
</tr>
<tr>
<td><strong>Loss of Interest in Pleasure</strong></td>
<td>• No longer participates in favorite activities</td>
</tr>
<tr>
<td></td>
<td>• Reinforcers no longer valued</td>
</tr>
</tbody>
</table>

Hughes, 2006

"Depression"
## Depression

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<thead>
<tr>
<th>DSM-IV-TR Symptom for Depression</th>
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</table>
| **Weight Change/Appetite Change** | • Measured weight changes  
• Increased refusals to come to table to eat  
• Unusually disruptive at meal times  
• Constant food seeking behaviors |
| **Insomnia**                     | • Disruptive at bed time  
• Repeatedly gets up at night  
• Difficulty falling asleep |
<table>
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<tr>
<th>DSM-IV-TR Symptom for Depression</th>
<th>Presentation in Someone with ID</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychomotor Agitation</strong></td>
<td>• Restlessness, Fidgety, Pacing</td>
</tr>
<tr>
<td></td>
<td>• Increased disruptive behavior</td>
</tr>
<tr>
<td><strong>Psychomotor Retardation</strong></td>
<td>• Sits for extended periods</td>
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<td></td>
<td>• Moves slowly</td>
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<td></td>
<td>• Takes longer than usual to complete activities</td>
</tr>
<tr>
<td>DSM-IV-TR Symptom for Depression</td>
<td>Presentation in Someone with ID</td>
</tr>
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<td>----------------------------------</td>
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</tr>
<tr>
<td><strong>Fatigue/Loss of Energy</strong></td>
<td>● Needs frequent breaks to complete simple activity</td>
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<td>● Slumped/tired body posture</td>
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<tr>
<td></td>
<td>● Does not complete tasks with multiple steps</td>
</tr>
<tr>
<td><strong>Feelings of Worthlessness</strong></td>
<td>● Statements like “I’m dumb,” “I’m retarded,” etc.</td>
</tr>
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<td></td>
<td>● Seeming to seek punishment</td>
</tr>
</tbody>
</table>

Hughes, 2006
<table>
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<th>DSM-IV-TR Symptom for Depression</th>
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</table>
| Lack of Concentration/Diminished Ability to Think | • Decreased work output  
• Does not stay with tasks  
• Decrease in IQ upon retesting |
| Thoughts of Death | • Preoccupation with family member’s death  
• Talking about committing or attempting suicide  
• Fascination with violent movies/television shows |
Depression

Treatment Strategies

- Antidepressant medication
- Psychotherapy (individual and/or group)
- Regular exercise
- Regular scheduling of pleasurable activities
- Learning stress management strategies
- Social skill training
- Positive behavioral supports
BIPOLAR DISORDER
Bipolar Disorder

• Causes mood swings

• Persons with Bipolar Disorder may have periods of mania, depression as well as normal moods

• During manic episode, person will display oversupply of confidence and energy
Bipolar Disorder

- Duration of mania or depressed cycle varies lasting for days to months

- Without treatment, school, job performance and relationships may suffer and dangerous behavior can occur
Bipolar Disorder

Two Types

1. Bipolar I
   • Characterized by one or more manic or mixed episodes

2. Bipolar II
   • Characterized by one or more major depressive episodes and at least one hypomanic episode
     • Hypomanic episode is a less intense episode of mania
### Bipolar Disorder

<table>
<thead>
<tr>
<th>DSM IV-TR Symptoms of Mania</th>
<th>Presentation in Someone with ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Euphoric, Elevated or Irritable Mood</td>
<td>• Smiling, hugging or being affectionate with people who previously were not favored by the individual</td>
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<td></td>
<td>• Boisterousness</td>
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<td></td>
<td>• Over-reactivity to small incidents</td>
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<td></td>
<td>• Extreme excitement</td>
</tr>
<tr>
<td></td>
<td>• Excessive laughing and giggling</td>
</tr>
<tr>
<td></td>
<td>• Self-injury associated with irritability</td>
</tr>
<tr>
<td></td>
<td>• Enthusiastic greeting of everyone</td>
</tr>
</tbody>
</table>

Hughes, 2006
## Bipolar Disorder

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<thead>
<tr>
<th>DSM IV-TR Symptoms of Mania</th>
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</table>
| Decreased Need for Sleep   | • Behavioral challenges when prompted to go to bed  
|                             | • Constantly getting up at night  
|                             | • Seems rested after not sleeping (i.e., not irritable due to lack of sleep as is common in depression) |

Hughes, 2006
### Bipolar Disorder

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<tr>
<td>Inflated Self-esteem/Grandiosity</td>
<td>• Making improbable claims (e.g., is a staff member, has mastered all necessary skills, etc.)</td>
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<tr>
<td></td>
<td>• Wearing excessive make-up</td>
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<td></td>
<td>• Dressing provocatively</td>
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<td></td>
<td>• Demanding rewards</td>
</tr>
</tbody>
</table>

Hughes, 2006
<table>
<thead>
<tr>
<th>DSM IV-TR Symptoms of Mania</th>
<th>Presentation in Someone with ID</th>
</tr>
</thead>
</table>
| More Talkative/Pressured Speech | • Increased singing  
|                                | • Increased swearing  
|                                | • Perseverative speech  
|                                | • Screaming  
|                                | • Intruding in order to say something  
|                                | • Non-verbal communication increases  
|                                | • Increase in vocalizations |

Hughes, 2006
## Bipolar Disorder

<table>
<thead>
<tr>
<th>DSM IV-TR Symptoms of Mania</th>
<th>Presentation in Someone with ID</th>
</tr>
</thead>
</table>
| **Distractibility**         | • Decrease in work/task performance  
                             | • Leaving tasks uncompleted  
                             | • Inability to sit through activities (e.g., favorite TV show) |

Hughes, 2006
<table>
<thead>
<tr>
<th>DSM IV-TR Symptoms of Mania</th>
<th>Presentation in Someone with ID</th>
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</thead>
</table>
| Agitation/Increase in Goal Directed Behavior | • Pacing  
• Negativism  
• Working on many activities at once  
• Fidgeting  
• Aggression  
• Rarely sits |
| Excessive Pleasurable Activities | • Increase in masturbation  
• Giving away/spending money |

Hughes, 2006
Bipolar Disorder

Treatment Strategies

• Mood stabilizing and antidepressant medication
• Psychotherapy with a focus on understanding and managing the disorder
• Environmental and social modification (i.e. increase supervision to insure safety)
• Positive Behavioral Supports
Overview of the Diagnostic Manual for Persons with Intellectual Disabilities
DM-ID
Diagnostic and Statistical Manual of Mental Disorders

-Published by the American Psychiatric Association

-Based on 5 Axis

_Axis I_: Clinical disorders, including major mental disorders, and learning disorders

_Axis II_: Personality disorders and mental retardation (although developmental disorders, such as Autism, were coded on Axis II in the previous edition, these disorders are now included on Axis I)

_Axis III_: Acute medical conditions and physical disorders

_Axis IV_: Psychosocial and environmental factors contributing to the disorder

_Axis V_: Global Assessment of Functioning

-Used to help determine a diagnosis

-Does not include information on treatment or cause

-Most current version was released in 2000
Limitations of DSM System

- Diagnostic Overshadowing (Reiss, et al, 1982)

- Applicability of established diagnostic systems is increasingly suspect as the severity of ID increases (Rush, 2000)

- DSM Systems relies on self report of signs and symptoms
Developed By
National Association for the Dually Diagnosed
(NADD)

In association with
American Psychiatric Association
(APA)

Partial Funding from the Joseph P. Kennedy, Jr. Foundation
Published by the NADD Press, 2007
DM–ID: Two Manuals

Diagnostic Manual – Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability

Robert J. Fletcher, DSW, ACSW, Chief Editor
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Department of Psychiatry
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Editor of the *DSM-IV-TR*
• An adaptation to the *DSM-IV-TR*

• Designed to facilitate a more accurate psychiatric diagnosis

• Based on Expert Consensus Model

• Covers all major diagnostic categories as defined in *DSM-IV-TR*
• Provides a wealth of information to help with diagnostic process

• Provides clear examples of how specific diagnostic symptoms should be interpreted

• Addresses pathoplastic effect of ID on specific psychiatric disorders

• Designed with a developmental perspective to help clinicians to recognize symptom profiles in adults and children with ID

Fletcher, 2008
Description of DM-ID (continued)

• Provides state-of-the-art information about mental disorders in persons with ID

• Provides adaptations of criteria, where appropriate

• Empirically-based approach to identify specific psychiatric disorders in persons with ID
Two Special Added-Value Chapters

- Assessment and Diagnostic Procedures (Chapter 2)

- Behavioral Phenotype of Genetic Disorders (Chapter 3)
Assessment & Diagnostic Procedures: Chapter 2

- Historical data to collect
- Use of language/communication
- Assessment of medical factors
- Understanding and interpreting symptoms
- Behavioral Phenotype of Genetic Disorders
- Psychometric assessment tools
- Axis IV
  - Suggest general considerations for Psychosocial Environment problems for people with ID
Assessment of Medical Conditions

- Constipation → distress
- Hypothyroidism → depressive symptoms
- Hyperthyroidism → manic episode
- Diabetes → behavioral side effects
### Behavioral Phenotype of Genetic Disorders: Chapter 3

<table>
<thead>
<tr>
<th>Syndrome</th>
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<tbody>
<tr>
<td>Angelman Syndrome</td>
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<tr>
<td>Cri-du-Chat (5p-) Syndrome</td>
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<tr>
<td>Down Syndrome</td>
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<tr>
<td>Fetal Alcohol Syndrome</td>
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<tr>
<td>Fragile-X Syndrome</td>
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<tr>
<td>Phenylketonuria</td>
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<tr>
<td>Prader-Willi Syndrome</td>
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<tr>
<td>Rubenstein-Taybi Syndrome</td>
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<td>Smith-Magenis Syndrome</td>
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<tr>
<td>Tuberous Sclerosis Complex</td>
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<td>Velocardiofacial Syndrome</td>
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<td>Williams Syndrome</td>
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## Phenotype and Proposed Behavioral Phenotype for Down Syndrome

<table>
<thead>
<tr>
<th>Phenotype</th>
<th>Proposed Behavioral Phenotype</th>
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<tbody>
<tr>
<td><strong>Childhood</strong></td>
<td>Oppositional and defiant; Attention-Deficit/Hyperactivity Disorder (ADHD); social, charming personality “stereotype”</td>
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<tr>
<td><strong>Adulthood</strong></td>
<td>Depressive disorders; Obsessive-Compulsive Disorder; other anxiety disorders; dementia of the Alzheimer’s Type; mental disorders associated with hypothyroidism</td>
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*Levitas, et al, 2007*
DM-ID
Diagnostic Chapter Structure

- Review of Diagnostic Criteria
  - General description of the disorder
  - Summary of *DSM-IV-TR* criteria

- Issues related to diagnosis in people with ID

- Review of Literature/Research
  - Evaluating level of evidence
• Application of Diagnostic Criteria to People with ID
  • General considerations
  • Adults with Mild to Moderate ID
  • Adults with Severe or Profound ID
  • Children and adolescents with ID
• Etiology and Pathogenesis
  • Risk Factors
  • Biological Factors
  • Psychological Factors
  • Genetic Syndromes
# DM-ID

## Diagnostic Chapter Structure

### Diagnostic Criteria

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria Mild-Moderate ID</th>
<th>Adapted Criteria Severe-Profound ID</th>
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<tbody>
<tr>
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<tr>
<td>DSM-IV-TR Criteria</td>
<td>Adapted Criteria for ID (Mild to Profound)</td>
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Addition of symptom equivalents

Omission of symptoms

Changes in symptom count

Modification of symptom duration

Adaptation of the DSM-IV-TR Criteria
Adaptation of the DSM-IV-TR Criteria

• Modification of age requirements
• Addition of explanatory notes
• Criteria Sets that do not apply
Adaptation of *DSM-IV-TR* Criteria Change in Count and Symptom Equivalent

### Major Depressive Episode

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria for Mild to Profound ID</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> Five or more of the following symptoms have been present during the same 2 week period and represent a change from previous functioning. At least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.</td>
<td><strong>A.</strong> <em>Four</em> or more symptoms have been present during the same 2 week period and represent a change from previous functioning. At least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure or (3) <strong>irritable mood</strong>.</td>
</tr>
</tbody>
</table>

Charlot, et al, 2007
### Intermittent Explosive Disorder

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria for ID (Mild to Profound)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Several discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property.</td>
<td>A. <strong>Frequent episodes that last for at least two months</strong> of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property.</td>
</tr>
</tbody>
</table>

Rifkin & Barnhill, 2008
## Adaptation of *DSM-IV-TR* Criteria

**Modification of Age**

### Antisocial Personality Disorder

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria for Individuals with ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:</td>
<td>A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 18 years, as indicated by three (or more) of the following:</td>
</tr>
<tr>
<td>B. The individual is at least age 18 years</td>
<td>B. The individual is at least age 21 years</td>
</tr>
<tr>
<td>C. There is evidence of Conduct Disorder with the onset before age 15 years</td>
<td>C. There is evidence of Conduct Disorder with onset before age 18 years</td>
</tr>
</tbody>
</table>
## Manic Episode

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria for Mild to Profound ID</th>
</tr>
</thead>
</table>
| **A.** A distinct period of abnormally persistently elevated, expansive or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary) | **A.** No adaptation.  
**Note:** Observers may report that the individual with ID; *has loud inappropriate laughing or singing, is excessively giddy or silly; is intrusive, getting into other’s space; and smiles excessively and in ways that are not appropriate to the social context. Elated mood may be alternating with irritable mood* |

Charlot, et al, 2007
Preventing Crisis

Transitional Stages in the Life of Families with ID

- Life transitions
- Predicable crises
- Prevention
- Intervention
Predictable Crisis & Prevention/Intervention

• Confirmation/realization of diagnosis of ID
• Birth of Siblings
• Starting school
• Puberty & adolescence
Predictable Crisis & Prevention/Intervention

- Sex and dating
- Being surpassed by younger siblings
- Emancipation of siblings
- End of education
Predictable Crisis & Prevention/Intervention

- Out-of home placement and/or residential moves
- Staff/client relationships
- Inappropriate expectations
- Aging, Illness and/or death of parents

Levitas and Gilson, 1989
Predictable Crisis & Prevention/Intervention

- Death of Peers or loss of friends
- Medical illness
- Psychiatric illness
- Other
Review of Mental Health Professionals

- Individuals who might work with your clients:
  - Psychiatrist
  - Psychologist
  - Social Worker
  - Marriage Family Therapist
  - Behavior Analyst
Review of Mental Health Professionals

- Psychiatrist
  - A medical doctor who specializes in treating mental health related disorders.
  - Completed medical school, usually is an MD or DO
  - Can evaluate and diagnose mental health disorders
  - Can prescribe psychotropic medications
Clinical Psychologist
  - Has a doctoral degree in psychology and a license to practice
  - Can diagnose mental health disorders
  - Work directly with clients to implement treatment for mental health needs
  - May be done in 1:1 therapy or group therapy sessions
  - Cannot prescribe medications
Review of Mental Health Professionals

- Licensed Clinical Social Worker
  - Has a master’s degree in Social Work and a license from the state, LCSW after name
  - Can diagnose mental health disorders
  - Usually works directly with client 1:1 or in groups settings
  - May address environmental/social issues affecting the client
  - Cannot prescribe medications
Review of Mental Health Professionals

- Marriage and Family Therapist
  - Has a master’s degree in marriage and family therapy, licensed, MFT after name
  - Evaluate and treat mental health and emotional disorders
  - Focus on the role of the individual in relationship networks
  - May be 1:1 or family therapy sessions
  - Cannot prescribe medications
Review of Mental Health Professions

- Behavior Analyst
  - Has a master’s degree and additional curriculum and experience, licensed, BCBA after name
  - engage in the specific and comprehensive use of principles of learning, including operant and respondent learning, in order to address behavioral needs
  - Develops a behavior plan for clients, focus is on changing behavior
  - Cannot prescribe medication
There are many types of mental health services your clients may be able to access:

- Support Groups
- Individual or group therapy
- Drop In/Club House settings
- Partial hospitalization
- Inpatient Treatment
Review of Mental Health Services

- Support Groups
  - May be led by a mental health professional or may be peer lead
  - In community settings
  - May be ongoing or run for a set number of weeks
  - Example: Peer to Peer groups run through NAMI run by mentors who have a mental health diagnoses themselves.
Review of Mental Health Services

- Individual or group therapy
  - Usually done with a clinical psychologist, social worker, or marriage family therapist
  - Sessions are usually an hour long, once a week or once every other week
  - Usually done in the community, although some providers may be willing to come to the facility
  - May use different therapeutic methods (e.g. psychoanalytic or cognitive behavioral)
  - Groups may be supportive in nature or psychoeducational (teaching the members about their mental health disorder)
Review of Mental Health Services

- Club House/Drop In programs
  - Usually consumer run programs
  - Place for peer support, social interaction, vocational support, and recreation opportunities
  - Example: Wellness Centers run by Pacific Clinics
Partial Hospitalization Programs
- Have a daily schedule much like a day program M-F
- Take place at an outpatient clinic
- Usually run by a team including a psychiatrist, social worker, and RN
- Good for clients who also have substance abuse issues
- Example: Partial Hospitalization Program at Charter Oak: M-F 9am to 2:15 pm.
Inpatient Programs

- The person is admitted to a psychiatric hospital for treatment
- Seen by a team of professionals including psychiatrist, therapist (psychologist or social worker), psychiatric RNs
- Medication can be adjusted and closely monitored
- Restrictive environment
- Need for collaboration when discharge planning is done
- Example: DDMI Wing at College Hospital
Importance of Collaboration

To help your clients enhance their mental wellness you need to collaborate with their mental health services

- Make sure you understand the purpose for psychotropic medications and any side effects
- Help with consistent attendance to any outside mental health resources
- Make sure the right professionals are working with the client
- Communicate with the mental health professional about those biopsychosocials issues that might impact the client’s functioning.
- Invite mental health professionals to your IPP meetings
- Communicate with the SC about any new mental health resources
- Anticipate the challenges that transitions and life events may create
Resources

For more information:

- The NADD for information on dual diagnosis: www.nadd.org
- Information about mental health and community resources: www.nami.org
- Information about local wellness centers and outpatient programs: www.pacificclinics.org
- Information about college hospital’s DDMI wing: Stephen Mouton smouton@sgprc.org or http://psychiatrichospitalization.com/
- Information on mental health professionals:
  - Psychiatrist: American Psychiatric Association www.psych.org
  - Psychologists: American Psychological Association www.apa.org
  - Social Workers: National Association of Social Workers www.naswdc.org
  - Marriage Family Therapists: American Association for Marriage Family Therapists www.aamft.org
  - Behavior Analyst: Behavior Analyst Certification Board www.bacb.com
  - California Board of Behavioral Sciences www.bbs.ca.gov
Thank you!

- Please complete your post-training survey to receive your certificate
- If you would like a copy of this presentation emailed to you please contact:
  - Jennifer Taylor: jtaylor@sgprc.org  909-868-7783

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