TREATING MENTAL ILLNESS IN THE DEVELOPMENTALLY DISABLED POPULATION

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EDUCATIONAL OBJECTIVES: AS A RESULT OF THIS SESSION, PARTICIPANTS WILL

- Appreciate mental health issues in people with developmental disabilities.
- Recognize limitations in psychiatric diagnosis in this patient population
- Utilize primary care treatment options to address mental health problems

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GENERAL CONCEPTS

- Often challenging population
  - Poor communication/comprehension
  - Poor impulse control
  - Wide variability in medication response
- Often a very rewarding population
  - Small changes can = Big effect
  - Often mental health issues have not been addressed
    - Straightforward interventions can work
  - Family members are often very supportive

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GENERAL CONCEPTS

- Knowing the Exact Genetic Syndrome Can
  - Help with some interventions
  - Help parents and genetic counseling
  - Help get services

- Knowing the Exact Genetic Syndrome
  - Usually will not help with treatment of the difficult behaviors that are the primary concern
    - Aggression, self injurious behavior, impulsivity, ect

  - This will change in the future

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GENERAL CONCEPTS

- Knowing the Exact Psychiatric Diagnosis
  - Can guide treatment, types of intervention
  - Can help parents
  - Can help get services
- With Proper treatment difficult behaviors often improve
- Difficult to get Exact Psychiatric Diagnosis
  - Poor verbal skills, A lot of partial symptoms, cognitive deficits
  - Ex: Mood DO NOS

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SELF INJURIOUS BEHAVIOR (SIB)

- This is a very significant problem in the DDMR population
  - Reported rates range between five and 66%
  - Requires prompt comprehensive treatment
    - Examples: hitting self, biting self, eye poking, pinching, scratching, picking, head banging, purposeful rectal prolapse, self gagging

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SELF INJURIOUS BEHAVIOR (SIB)

- Can cause serious physical injury and death
- Requires increased need for restricted equipment
- National costs estimated at over 3 billion annually

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SELF INJURIOUS BEHAVIOR (SIB)

- Multiple theories and multiple neurotransmitter systems have been implicated.
- Environmental factors may include:
  - Escape from demands
  - Access to 1° re-enforcers (food, toys)
  - Access to attention
  - Escape from social interaction
  - Escape from interruption
  - Control
  - others

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CHALLENGING BEHAVIOR

- SIB included in term "Challenging Behavior"
  - Also physical aggression, marked oppositionality
- In this population "Challenging Behavior" is associated with psychiatric symptoms
  - Depression 4 times more prevalent with challenging behavior
  - Hypomania 3 times more prevalent
  - SIB is especially associated with anxiety
- These patients have limited ways of expressing emotion

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CHALLENGING BEHAVIOR

- "Challenging behavior" is often a symptom of psychiatric illness in the developmentally disabled
- If you diagnose and treat the **core** problem, the SIB/Aggression can improve

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AN APPROACH

- Interview patient, parents, DSPD care coordinator, support staff, find out "Challenging Behaviors"
  - Must have collateral info
- How long have they occurred?
- When did things change?
- What has changed?
- Why have things changed?

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EVALUATING CHANGE IN BEHAVIORS

- **Physical-Environmental-Emotional**
  - PEE
    - You'll remember it ☺
- **Physical**
  - medical illness i.e. ear infections, cavities, tooth abscess, pneumonia, etc
  - Genetic factors i.e., Dementia in Downs
  - Injuries: strained muscles, growing pains

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EVALUATING CHANGE IN BEHAVIORS

- **Environmental**:
  - These patients are very sensitive to their environment.
    - Change in staff, changing behavioral programs, changing offices, changing providers.
  - A big change for you may not be a big change for them and vice-versa
  - Eg: Loss of a care giver loss vs loss of a parent

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EVALUATING CHANGE IN BEHAVIORS

- How have they handled unavoidable change in the past?
- Has there ability to tolerate change, changed?

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EVALUATING CHANGE IN BEHAVIORS

- **Emotional**
  - Serious mental illness
    - Mood disorders, anxiety, psychosis, PTSD, reactive attachment disorder
  - Higher rates of **ALL** categories of psychiatric illness in this population
    - Isle of Wight studies 30-42 % (UK 1970)
    - Kishore et al. 60% (India 2004)
    - Dekker & Koot 26.3% (Netherlands, 2003)

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BEGIN TREATMENT

- Decide what the target symptoms will be
- Make the best attempt at a diagnosis and treat
  - For SIB try Atypical to get symptoms under control then treat underlying mood or anxiety disorder
  - Begin referral process

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BEGIN REFERRAL PROCESS

- Medicaid
- DSPD (Division of Services for People with Disabilities)
  - Can be on "waiting list" for years
- Additional Therapies
- Psychiatry, Neurology, Cardiology etc
- HOME clinic

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ATYPICAL ANTIPSYCHOTICS

- Risperdal
  - FDA approved for "irritability symptoms" autistic children ages 5-16
    - Not always effective
    - Avoid heroic dosing
    - Start low 0.25mg QHS or BID and increase
      - Have collateral sources of info on response
- Abilify
  - Also FDA approved for "irritability, autistic disorder-associated"
    - Start low 2 mg, increase slowly, no more than 5 mg/week
    - Can suppress WBC. Watch ANC
    - Range will be 5-10 mg
    - Doesn't affect prolactin levels much
    - Can be activating

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SOME OTHER ATYPICAL ANTIPSYCHOTICS

Name	Dosage Range	Comments
Qutiepine (Seroquel)	Start 25 mg BID up to 800mg daily in divided doses	Patients may not like anxiolytic "feel"
Olanzapine (Zyprexa)	Start 2.5 to 5mg daily up to 30mg daily	Sedation and weight gain are biggest problems
Zipraxidone Geodon	Start 20-40mg BID up to 80mg BID	"Weight neutral" Can prolong QT

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ANTIPSYCHOTICS IN GENERAL

- Too much can be a problem
- Too little can be a problem
- Watch for akathesia
- Watch for dystonia
  - Cogentin or benadryl can be used to prophylax against this
- Can exacerbate diabetes
  - Increase level of monitoring
- This class can be quite useful in time of Crisis

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SSRI'S

- Use for anxiety and/or depression
- Start low and go slow.
- All SSRI's can really agitate this population
- Still first line for depression and anxiety

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SSRI'S

- Anxiety treatment - higher dose and wait longer for results
- Significantly protein bound
  - Adolescents can have increased protein in blood
- At least very other week follow up initially
- Ex: Fluoxetine start 5 or 10mg daily and increase
  - Up to 60 or even 80mg daily if tolerated for severe anxiety disorders i.e. OCD
  - Watch out of Seritonin Syndrome

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MOOD STABILIZERS

- Co-morbid seizure disorder is common
- Maximize the mood stabilizers they are already on
  - Wide variability to side effects
  - Wide variability to clinical effects
- Ex: Depakote start 250mg BID-TID and increase to effective dose (VPA level ~100 mcg/mL) Max 60mg/kg/day

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MOOD STABILIZERS

- Lithium
- Blood draws may or may not be an issue
- Lithium level 0.8 ~1.2 mEq/L
  - Narrow therapeutic index in patients with poor communication
    - Check levels frequently, particularly if behavior changes
- Start 300 mg BID and increase 300mg every 3-7 days
  - Check trough blood level at 300/600 or 600/600
  - 5 half-lives (T1/2) to reach steady state

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BENZODIAZEPINES

- Response can be quite variable
  - They can help
  - They can totally backfire (dis-inhibition)
    - Recent HOME clinic case where 0.25mg BID of clonazepam (Klonopin) in a large male was quite agitating
- Watch drug-drug interactions and side effects
  - Check DD interactions regularly
- Ex: clonazepam start 0.25mg BID and increase

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STIMULANTS

- Can help with ADHD symptoms to include impulsivity, following directions
  - Usually not as a robust response as with neurotypical population
- Can exacerbate tics
- Newer preparations are improved forms of delivery, same active ingredients
  - Methylphenidate HCL (MPH) = Ritalin, Concerta, Metadate
  - Dextroamphetamine + levo-amphetamine = Adderall, Adderall XR, etc
- Ex: Concerta begin 18mg daily and increase
  - Medium dose is about 1mg /kg/day
  - Light dose is 0.5mg /kg/day

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OTHER AGENTS

- Clonidine
  - Can help with aggression, impulsivity
  - Often too sedating
  - BID to TID dosing
  - Start 0.05 to 0.1mg BID
  - Need to Taper
  - Patch Available
  - Monitor BP

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OTHER INTERVENTIONS

- Medications are rarely enough
- Other interventions include Speech/Language therapy, Physical therapy, Social skills training, Individual and group therapies
- Comprehensive care really requires a team

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PARTING THOUGHTS

- Prompt intervention can decrease the dangerousness of the situation
- Initial intervention important step toward comprehensive care
- Can be a difficult to treat population but also very rewarding

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QUESTIONS?

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