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
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
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, etc

• This will change in the future
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
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
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
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
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
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
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?
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
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
EVALUATING CHANGE IN BEHAVIORS

• How have they handled unavoidable change in the past?
• Has there ability to tolerate change changed?
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)
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
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
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
# Some Other Atypical Antipsychotics

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage Range</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Quetiapine (Seroquel)</td>
<td>Start 25 mg BID up to 800 mg daily in divided doses</td>
<td>Patients may not like anxiolytic “feel”</td>
</tr>
<tr>
<td>Olanzapine (Zyprexa)</td>
<td>Start 2.5 to 5 mg daily up to 30 mg daily</td>
<td>Sedation and weight gain are biggest problems</td>
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<tr>
<td>Ziprazidone Geodon</td>
<td>Start 20-40 mg BID up to 80 mg BID</td>
<td>“Weight neutral” Can prolong QT</td>
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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
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
**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 Serotonin Syndrome
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
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
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
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
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
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
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
QUESTIONS?