Identification of Mental Health Conditions in Youth with Intellectual and Developmental Disabilities (IDD)

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Objectives

- Understand why it is essential to identify co-occurring mental health (MH) conditions in youth with IDD.
- Review rates of co-occurring MH conditions amongst youth with IDD.
- Discuss challenges with the assessment of youth with IDD.
- Provide recommendations to assist with identifying co-occurring MH conditions in youth with IDD.

Who are we talking about?

- Youth with **intellectual disability**
  - significant limitations in both intellectual functioning and in adaptive behavior

- Youth with **developmental disabilities**
  - impairment in physical, learning, language, or behavior areas
  - begin during the developmental period, may impact day-to-day functioning, and usually last throughout a person's lifetime.

- Youth with **Autism Spectrum Disorder**
  - associated impairment in language and intellectual functioning
  - often more significantly impacted and referred to as having 'severe autism' or 'profound autism'

Why are we talking about this?

- Youth with IDD, especially those with Autism Spectrum Disorder (ASD)
  - Substantially greater risk of developing MH problems
  - MH co-morbidities are often missed or hidden in the context of the IDD
  - This can lead to reduced quality of life and increased burden of care.

- Essential that there be identification of the MH co-morbidity in order support access to appropriate behavioral health services and improve outcomes for youth with IDD.

Why are we talking about this?

- In Washington State - known shortage in the workforce that is capable of providing appropriate behavioral health services to the IDD population.

- This, along with other factors, has resulted in a rise in behavioral health crisis events and inpatient hospital encounters, including both emergency department visits and inpatient admissions.

- For context…
  - Children with ASD are 6 times more likely to be psychiatrically hospitalized than children without ASD.
  - The leading cause of any type of hospitalization for youth with ASD greater than the age of 5 years is for psychiatric conditions.

Why are we talking about this?

- Healthcare providers in WA State need to increase their knowledge of how MH conditions can manifest uniquely in IDD and how it can arise from consequences of IDD in order to improve approaches to effective treatment that carry the potential for

  - preventing enduring or entrenched trajectories of impairment
  - improving quality of life
  - avoiding unnecessary polypharmacy
  - avoiding placement in overly restrictive environments

Rates of co-morbidity of mental health and IDD

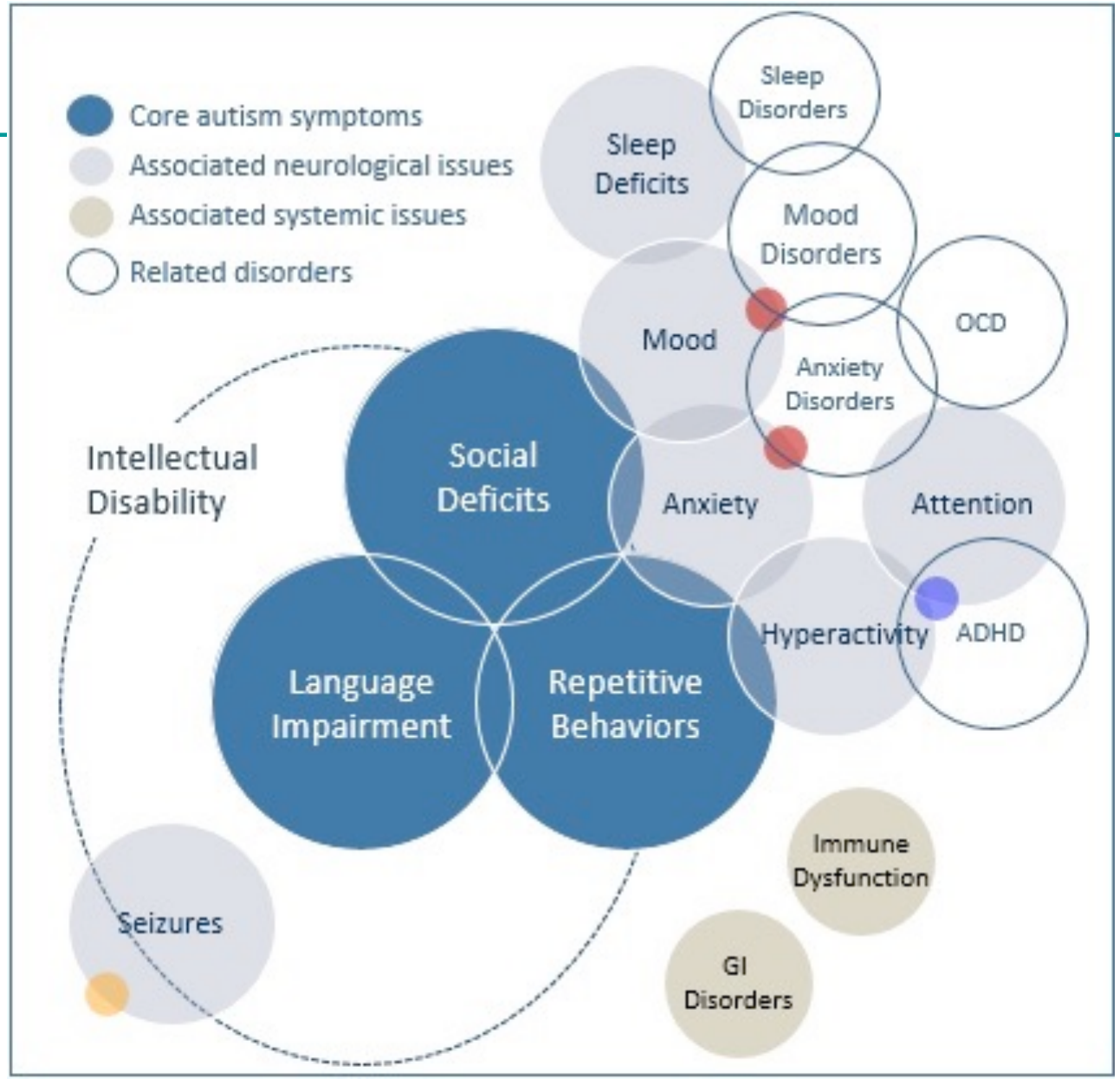
- Individuals with DD are at fivefold risk for future MH problems compared to controls with 40–50% experiencing such problems, including depression, anxiety, substance abuse, disruptive behaviors and psychosis.

- A sample of 101 preschool and elementary school-aged children with ASD found that over half of the sample met criteria for generalized anxiety disorder (66.5%), specific phobias (52.7%) and attention deficit hyperactivity disorder (52.7%).

- In a study of 112 youth with ASD, ages 10-14, 70% had a least one co-morbid psychiatric diagnosis. The most common were social anxiety (29.2%), ADHD (28.2%) and oppositional defiant disorders (28.1%).

- In this same sample, 52% had multiple diagnoses; 38% had 3 or more disorders.

- Pure autism is very rare.
- In some cases, the co-occurring conditions can cause a greater barrier to success than the core features of ASD



Closer look at trauma and IDD

- Studies have estimated that having a chronic health condition, including an IDD, is associated with having an 83% higher likelihood of a child experiencing 2 or more Adverse Childhood Events (ACEs) and 73% higher likelihood of experiencing 3 or more ACEs by the age of five.

- Children with IDD are bullied 1.5 to 2 times more than their peers without IDD.

- Children with IDD are exposed to traumatizing incidents of physical restraint and seclusion which are not typically experienced by their peers without IDD.

- Children and youth with IDD are up to 4 times more likely to witness family domestic violence in comparison to controls. According to a study on the prevalence of various types of ACEs experienced by children with IDD, the most frequent were parental separation/divorce (63.8%), parental mental health problems (33.3%) and to have witnessed violence against a parent (28.9%)

Challenges with identifying MH conditions in IDD

- There are few conditions in psychiatry that are without criteria that include the expressed thoughts or feelings of the individual.
- Current screening tools very often rely on self-report and parent/caregiver report in assessing for the presence of mood or anxiety problems.
- Youth with IDD, particularly those with communication problems may be unable to participate in a personal interview.
- Parents or caregivers may be reluctant or uncertain about their ability to make inferences regarding the mental health of the youth with IDD.

Challenges with identifying MH conditions in IDD

- The presence of severe challenging behavior (e.g., aggression, self-injurious behaviors, property destruction, elopement, pica) often requires comprehensive and multidisciplinary assessment to clarify function of behavior, co-morbid psychiatric symptoms (e.g., anxiety, irritability), and possible medical complications (e.g., seizures, pain).

Disruptive Behaviors

- The symptoms that typically bring individuals to the attention of the mental health system are disruptive behaviors.
  - Aggression (hitting, biting, kicking)
  - SIB (self biting, head banging)
  - Property Destruction (breaking/throwing items)-
  - Other Behaviors (elopement, pica)
- The most common reason for a psychiatric admission for youth with ASD includes aggression, self-injurious behavior, property destruction and tantrums.
- Disruptive behaviors are often one of the first symptoms you might see that would indicate a psychiatric issue

How can psychiatric symptoms contribute to disruptive behavior?

- ADHD: Inattention/hyperactivity/impulsivity → disruptive behavior to escape mentally challenging tasks, elopement in public settings
- Anxiety: Fear → aggression, elopement (flight or flight)
- OCD symptoms: Compulsions being interrupted → aggression
- Depression: Irritability → aggression or self-injury
- PTSD: hypervigilance or flashbacks → agitation; autonomic hyperarousal → aggression or self-harm; nightmares → unexplained sleep problems

BioBehavioral Model of Assessment

- **Biologic/Medical**
  - Assess for underlying psychiatric issue (e.g., anxiety, irritability) contributing to disruptive behavior
  - Assess or refer for underlying medical complications contributing to disruptive behavior

- **Skill-based**
  - Assess ability to communicate, consider best communication system

- **Behavioral**
  - Understanding and manipulating antecedents, and consequences to alter behavior and to identify function of severe behavior

Tools to assess function of behavior

- Functional Assessment Interview (FAI; O'Neill, Harner, Albin, Spargue, Storey, & Newton, 1997)
- Questions About Behavioral Function (QABF; Paclawskij, Matson, Rush, Smalls, Z& Vollmer, 2000)
- Functional Assessment Screening Tool (FAST; Florida Center on Self-Injury, 2005)
- Motivation Assessment Scales (Durand & Crimmins, 1988)

Screening for psychiatric symptoms

- A comprehensive clinical interview should include individual and/or caregiver information to elicit common psychiatric symptoms that can present with IDD.
  - Inattention, distractibility
  - Hyperactivity, impulsivity
  - Irritability
  - Other mood symptoms
  - Psychotic symptoms
- The clinical interview should include questions to understand onset of a problem or change in behavior, timing and frequency of problem, and situations in which the problem is present and interfering.
- Questionnaires should be provided to other caregivers and teachers to assess for occurrence of problem across settings.

Screening tools to assist with diagnostic assessments

- The Developmental Behaviour Checklist (DBC) (Einfeld & Tonge, 1992, 2002)
  - Questionnaire used for the assessment of behavioral and emotional problems of young people aged 4-18 years with developmental and intellectual disabilities. It is completed by parents or other primary caregivers or teachers, reporting problems over a six month period.

- While there are not currently any other validated measures that we know of that have been specifically designed to assist with diagnosing MH problems in youth with IDD, there can be significant value in collecting data using validated screening tools and semi-structured interviews to provide additional information about function and treatment goals. The results can be used in a more qualitative versus quantitative fashion.

- Many measures have both self-report and caregiver report forms.

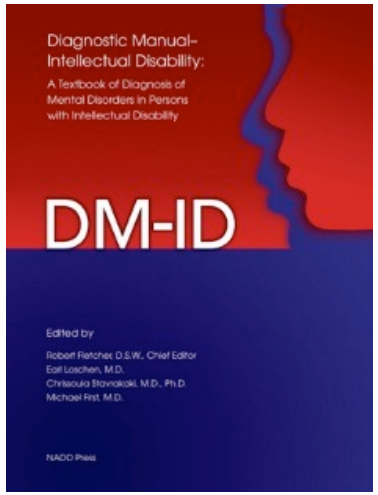
Screening tools to assist with diagnostic assessments

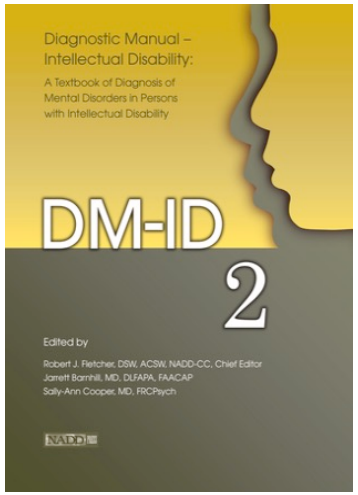
- When administering to youth with IDD who have verbal capabilities, it may be useful to modify questions to make them more concrete and use visual tools like emotion faces to help the youth identify their own experience of certain feelings.

- Examples of validated measures commonly used in assessment with youth:
  - ❖Child and Adolescent Trauma Screen (CATS) – self-report and caregiver report - available free online
  - ❖Screen for Child Anxiety Related Disorders (SCARED) - self-report and caregiver report - available free online
  - ❖Revised Children's Anxiety and Depression Scale (RCADS) - self-report and caregiver report - available free online

Diagnostic Manual – Intellectual Disability

- The development and publication of the Diagnostic Manual-Intellectual Disability (DM-ID and DM-ID 2) represents a comprehensive attempt to bridge criteria from the Diagnostic Statistical Manual (DSM) for individuals with all levels of intellectual disability.





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Questions

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