PSYCHIATRIC ASPECTS OF INTELLECTUAL DISABILITY

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Please Turn Off Your Cell Phone

נא לכבות פלאפוןינו
Today’s menu

- General overview of intellectual disability
- Psychiatry of intellectual disability
Mental Retardation: An Overview

- Terminology
- Definitions
- Prevalence
- Levels of MR
- Aetiology
- Complications
- Prevention
- Management
Intellectual disability (I): Terminology

- Mental retardation (MR)
- Mental handicap
- Intellectual disability (ID)
- Developmental disability
- Intellectually challenged
- Learning disability (LD)
Intellectual disability (II): Definitions

- ICD-10
- DSM 5
- The Israeli definition
- The common feature: Delayed, not deviant, development
In European countries 2% mild learning disability, 0.35% severe learning disability (Roy et al., 2000)

In Israel about 0.4 % of the general population use services of the “Sherut”
Intellectual disability (IV): Levels (ICD-10)

- Mild: IQ 50-69, adult mental age 9-12 y
- Moderate: IQ 35-49, adult mental age 6-9 y
- Severe: IQ 20-34, adult mental age 3-6 y
- Profound: IQ under 20, adult mental age under 3 y
Intellectual disability (V): Aetiology

- “None” (most)
- “Genetic”
- “Environmental” (Pre-, peri-, postnatal and later)
Intellectual disability: Aetiology- Genetic

- Down syndrome
- Fragile X
Intellectual disability: Aetiology - Genetic - Down syndrome

- The most common identifiable genetic cause of ID
- Mean IQ in moderate–severe ID range
- Characteristic personality
- Low rates of autistic-spectrum and attention-deficit disorders
- High rates of depression, Alzheimer’s disease, hypothyroidism
The commonest identifiable inherited cause of ID
- Mean IQ in mild-moderate ID range
- High rates of autistic-spectrum disorder and ADHD
- Particular cognitive problems
- Friendly albeit shy and socially anxious
- Autistic-like communicatory and ritualistic features
Intellectual disability: Aetiology-Environmental

- Pre-, peri-, postnatal and later
- Congenital infection, e.g., Rubella, CMV
- Toxins, e.g. FAS, medications, PKU
- Anoxia/starvation
- Neglect?
- Schizophrenia?
Differential Diagnosis of ID

- Sensory and communication problems
- Environmental neglect
- PDD
- Severe ADHD (especially inattentive type)
- Schizophrenia
- Other psychopathology
Intellectual disability: Prevention

- Pre-conception
  - Genetic counseling
- Post-conception / Antenatal
  - Health care, alcohol, ....
  - Screening for Tay-Sachs ...
- Postnatal
  - Hypothyroidism, PKU, general child care, early intervention…
Intellectual disability: Complications

- Physical
- Social
- Psychological
Intellectual disability: Management

- General medical
- Psychological
- Social
Public Service Announcement

How to identify if your cow has mad cows disease.

If your cow sounds like this then fire up the barbecue.

If your cow sounds like this may we suggest the fish.

(double click on speaker icons)
Psychiatry of intellectual disability

- What are the psychiatric aspects?
- Conceptual Issues
- Epidemiology
- Aetiology
- A recommended diagnostic approach
- “Common” psychiatric syndromes in ID
- Behavioral phenotypes
- Treatment
- New stuff
- The Schneider unit
- Policy / plans
What are the psychiatric aspects?

- Diagnosis and differential diagnosis of ID
- Treatment of disturbed people with ID
Psychiatry of Mental Retardation: Conceptual Issues

- The importance of accurate diagnosis
- Multiaxial systems
- A residual Israeli problem
The Epidemiology of Psychiatric Disturbance in ID

- Reported rates vary significantly from study to study
- Point prevalence of psychiatric disturbance is 10% to upwards of 60% (King et al., 1997)
- SES
- Sex
- IQ
The Aetiology of Psychiatric Disturbance in ID

- Direct biological effects on the brain
- Associated physical and sensory deficits
- Limited cognitive abilities
- Psychological effects
- Secondary, socially-mediated effects (including the negative effects of the "helping" systems)
- Drug (iatrogenic) effects
"Common" Psychiatric Syndromes in ID

- PDD
- Schizophrenia
- Depression
- Mania
- Dementia
- ADHD
- Conduct disorder
- Adjustment disorder
- PTSD
- Anxiety neuroses
- Organic brain syndromes
- Personality disorders
- Isolated symptoms
- No diagnosis
A recommended diagnostic approach

- Make a diagnosis
- The importance of good observational data
- The developmental approach
- Pitfalls in diagnosis
- Intake forms
- Standardized assessment
Four common conceptual problems

1. Definition of psychiatric disturbance
2. A psychiatric disturbance on organic background is still a psychiatric disturbance
3. “Medication balancing”
4. “This isn't ours, it’s for the Sherut”
Assessment: ‘From theory to practice’-ii

- Get a clear idea on the phone
- Get the referrer to do homework
- Try to get all relevant people together ab initio
- Use an intake form
- Ensure realistic expectations from all involved
- Try to develop personal relationships with key people; use every contact with professionals to “cultivate” them
‘FROM THEORY TO PRACTICE’-

III

- In ambulatory practice or inpatient wards
  - Separate history taking and mental state examination sessions
  - Invite all relevant people to get a balanced picture
  - Get background info from the beginning
  - Keep in mind the artificiality of the situation and the limits of the mental state examination

- In institutions etc.
  - Easier to do one big “round table” meeting
  - Try to see in vivo
  - Avoid too cozy a relationship with any one side
  - Remember ethical issues
So what about treatment?

Unknown to most students of psychology, Pavlov’s first experiment was to ring a bell and cause his dog to attack Freud’s cat.
Conduct full assessment

Use multiple informants

Physical examinations / investigations.

Formulation.

Treatment plan, as part of a broader care plan.

Explore non-medication management options.

Keep good clinical records.

Don’t just do something, stand there.
Primum non nocere

Clearly determined outcome measures

Teach the carers what to look for

Identify key person for medication
Strategies of successful treatment-iv-prescribing

- Start low, go slow
- Prescribe one medication at a time.
- Minimize polypharmacy
- NB drug-drug interactions
STRATEGIES OF SUCCESSFUL TREATMENT-III

- Close follow-up but infrequent changes.
- Consider withdrawing medication
- Document all relevant changes
- For ‘SOS’, provide appropriate information to carers
- Monitor ‘SOS’ regularly.
Concerns in ID:

- Increased confusion
- Cognitive impairment
- Unsteadiness
- Paradoxical excitement
Sleep disturbance - Melatonin

Coppola et al. (2004):
- Randomized, controlled cross-over study.
- Children, adolescents, and young adults at doses up to 9 mg daily.
- Sleep onset was improved in the active treatment group.
Tyrer et al, 2008:
Compared flexible doses of haloperidol, risperidone and placebo, in 86 non-psychotic patients presenting with aggressive challenging behaviour from ten centres in England and Wales, and one in Queensland, randomly assigned to haloperidol (n=28), risperidone (n=29), or placebo (n=29).
Findings- I: The good news

Aggression decreased substantially with all three treatments by 4 weeks.
Placebo group showed the greatest change (median decrease in MOAS score after 4 weeks=9 [95% CI 5–14] for placebo, 79% from baseline)
Antipsychotic drugs should no longer be regarded as an acceptable routine treatment for aggressive challenging behaviour in people with intellectual disability.
Strategies to reduce medication use

- Gradual reduction
- Do not make many changes at once
- Assess clinical effectiveness regularly
- Involve users/carers
Agencies working with people with ID: Non-mental health

- Schools
- Hostels
- Institutions
- Local Social services
- Division for People with ID of the Social Services Ministry
- Akim
- Bi‘zychut
Agencies working with people with ID: Mental health

- Generic psychiatry departments
- Schneider Developmental Psychiatry Outpatient Unit
- Beit Issie Shapiro Dual Diagnosis Unit
- Sehba ID clinic
- Shaar Menashe clinic
Diagnostic overshadowing

Atypical presentations; problems in communication.

Incorrect diagnosis or treatment

Prejudice/discrimination?
Obstacles to good services

- Diagnostic overshadowing
- Atypical presentations; problems in communication.
- Incorrect diagnosis or treatment
- Prejudice/discrimination?
How well does the current system work?

To examine opinions of psychiatrists regarding their relevant training, relevant level of knowledge / skills, attitudes towards people with dual diagnosis, opinions about psychiatric treatment of people with dual diagnosis.
PROCEDURE

Sample recruitment

Instruments
PARTICIPANTS

- 256 psychiatrists from psychiatric hospitals, community mental health, clinics, and general hospitals
- 54% male
- Average age 48
- Mean number of years since completion of medical studies: 22
Questionnaire

- Demographic and professional background
- Training, knowledge and skills in the field of DD
- Objective knowledge
- Attitudes and therapeutic perceptions regarding role of psychiatry in ID
- Opinions regarding the improvement of existing services
90% reported no specific training in diagnosis and treatment of people with DD.
30% reported on low levels of knowledge / skills.
87% strongly / very strongly agreed that there is a need to improve training in the field of DD.
<table>
<thead>
<tr>
<th>Topic</th>
<th>Reported level of knowledge</th>
<th>Required level of knowledge</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotropic treatment for people with ID</td>
<td>Unsatisfactory</td>
<td>Not at all</td>
<td>34.3</td>
<td>2.0</td>
</tr>
<tr>
<td></td>
<td>Satisfactory</td>
<td>Partially</td>
<td>51.9</td>
<td>17.6</td>
</tr>
<tr>
<td></td>
<td>Comprehensive</td>
<td>To a large extent</td>
<td>13.8</td>
<td>80.4</td>
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<td>Diagnosis of psychiatric illness among people with ID</td>
<td>Unsatisfactory</td>
<td>Not at all</td>
<td>40.0</td>
<td>2.4</td>
</tr>
<tr>
<td></td>
<td>Satisfactory</td>
<td>Partially</td>
<td>45.8</td>
<td>18.3</td>
</tr>
<tr>
<td></td>
<td>Comprehensive</td>
<td>To a large extent</td>
<td>14.2</td>
<td>79.4</td>
</tr>
<tr>
<td>Different treatment option for people with ID</td>
<td>Unsatisfactory</td>
<td>Not at all</td>
<td>61.3</td>
<td>0.4</td>
</tr>
<tr>
<td></td>
<td>Satisfactory</td>
<td>Partially</td>
<td>33.2</td>
<td>30.0</td>
</tr>
<tr>
<td></td>
<td>Comprehensive</td>
<td>To a large extent</td>
<td>5.5</td>
<td>69.6</td>
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<tr>
<td>Diagnosis of ID</td>
<td>Unsatisfactory</td>
<td>Not at all</td>
<td>39.3</td>
<td>33.7</td>
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<tr>
<td></td>
<td>Satisfactory</td>
<td>Partially</td>
<td>51.5</td>
<td>66.3</td>
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<tr>
<td>----------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Differential diagnosis between different factors related to ID</td>
<td>Unsatisfactory Satisfactory Comprehensive</td>
<td>48.5 44.8 6.6</td>
<td></td>
<td>Not at all Partially To a large extent</td>
</tr>
<tr>
<td>Communication problems among children / adults with DD</td>
<td>Unsatisfactory Satisfactory Comprehensive</td>
<td>55.9 36.0 8.1</td>
<td></td>
<td>Not at all Partially To a large extent</td>
</tr>
<tr>
<td>Behavioral phenotypes connected to specific syndromes</td>
<td>Unsatisfactory Satisfactory Comprehensive</td>
<td>60.5 34.5 5.0</td>
<td></td>
<td>Not at all Partially To a large extent</td>
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<tr>
<td>Dealing with personal attitudes toward ID</td>
<td>Unsatisfactory Satisfactory Comprehensive</td>
<td>33.9 58.1 8.1</td>
<td></td>
<td>Not at all Partially To a large extent</td>
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<tr>
<td>Psychotherapy for people with ID</td>
<td>Unsatisfactory Satisfactory Comprehensive</td>
<td>72.0 25.5 2.5</td>
<td></td>
<td>Not at all Partially To a large extent</td>
</tr>
</tbody>
</table>
OBJECTIVE KNOWLEDGE MEASURE (VIGNETTES)

General psychiatry
- 2% - three correct
- 40% - two correct
- 42% - one correct
- 15% - none

Child/adolescent psych.
- 22% - three correct
- 57% - two correct
- 20% - one correct
## Therapeutic perceptions - the role of psychiatry in ID

<table>
<thead>
<tr>
<th>Statement</th>
<th>% agree and strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists seldom have a role in diagnosing or treating behavioral problems among people with ID</td>
<td>8.3</td>
</tr>
<tr>
<td>Psychiatric problems are not common among people with ID</td>
<td>4.4</td>
</tr>
<tr>
<td>People with DD receive a relatively poor standard of psychiatric care</td>
<td>68.2</td>
</tr>
<tr>
<td>Insufficient community psychiatric services may lead to inappropriate prescription of antipsychotic medicines</td>
<td>84.6</td>
</tr>
<tr>
<td>People with ID often stay too long in psychiatric hospitalization</td>
<td>62.3</td>
</tr>
<tr>
<td>Statement</td>
<td>% agree and strongly agree</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>The acute hospitalization ward is adapted to people with severe ID and psychiatric problems</td>
<td>24.0</td>
</tr>
<tr>
<td>It is easy to refer to and liaise with social services for people with ID</td>
<td>22.2</td>
</tr>
<tr>
<td>People with ID are vulnerable to exploitation by other patients in general psychiatric department</td>
<td>88.1</td>
</tr>
<tr>
<td>My training has trained me to diagnose and treat people with DD</td>
<td>43.0</td>
</tr>
<tr>
<td>Psychiatric training in the field of ID should be offered as a training option for all residents</td>
<td>85.2</td>
</tr>
<tr>
<td>Inpatient psychiatric care should be provided in units dedicated to people with ID</td>
<td>64.3</td>
</tr>
</tbody>
</table>
Lack of skilled personnel - 94 %

Lack of knowledge among MH professionals - 83 %

Prejudice of MH workers - 47 %
WAYS TO IMPROVE SERVICES

- Provide theoretical and practical knowledge to all psychiatrists - 52 %
- Establish specialized psychiatric services - 36 %
- Create "local experts" - 30 %
Many participants felt they do not have enough knowledge / skills.

...Not explained by perception of lack of importance.

Subjective perception of lack of knowledge / training supported by findings regarding objective knowledge.

Most lack a senior psychiatrist for relevant consultation.
CONCLUSIONS

- Our findings provide at least a suggestion of inadequacy of existing services.
- The problem is probably with the basic model, rather than just its local implementation.
- There are various options for improving services.
The NDP Unit in Schneider Children’s Hospital (VI)-Vignettes

- B - the poor kid. (Mild ID and ADHD)
- E. - How can we get him to learn? (Mild ID and ??? ADHD-not)
- Z - can’t stand school.
- H - (Turner’s syndrome w. mod. ID and hearing problems)
Neurodevelopmental Psychiatry Outpatient Service in Schneider Children’s Medical Center

Staff

Whom do we see?

What do we do with them?

- Detailed psychosocial assessment
  - History
  - Examination
  - Collateral info
- Detailed feedback
The NDP Unit in Schneider Children’s Hospital (II)

- What do we do with them? (Cont.)
  - Work with parents (mostly behavioural advice)
  - Work with schools
  - Direct treatment
  - Family therapy
  - Medication
  - Long-term, low-intensity follow-up

- What do we see?
AGENTS OF CHANGE

- Neveh Yaakov scandal
- Schneider hospital
- Beit Issie Shapiro
- Group for the advancement of developmental psychiatry in Israel
- Psychiatric reform!
MENTAL HEALTH SERVICES IN ISRAEL- REFORM!

- Increased availability of services
- Expectation to provide quality services
- Separation of the provider and the regulator of services
The generic child/adult psychiatrist is the point (wo)man for mental health problems, no matter what the IQ level.

Yes we can!

Taking aim helps if you want to hit something.

Beware of diagnostic overshadowing.

Push for specialist services, or at least training.

Always look on the bright side of life.
These patients are often more complicated than the average patient...
...but it’s not rocket science...
...just make sure you make a proper diagnosis...
...don't be trigger happy...
...remember that a child with ID is first of all a child
And always look on the bright side of life.
THAT’S ALL, FOLKS!