Some assumptions…

People have…..
- Experience
- Compassion
- Knowledge
- Innovation
- Interest
- Person-centered approach

Keep in mind an open mind…

Things are not always what they seem…..
It is impossible for a man to learn what he thinks he already knows.

Concepts to cover…

- Dual Diagnosis via the biopsychosocial model-use of case example
- Values in labels
- The multidisciplinary team
- The choices we make
- Seizures and alternative theories

Stats attack…

- Approximately 1% of the population will have a developmental disability
- About 37% of individuals with a developmental disability also have a mental illness (March 2001)
- There are approximately 3,700 individuals with a dual diagnosis in the community of York Region
• Will likely experience some form of sexual assault or abuse during their lifetime (Sobsey & Varnhagen, 1989).
• Often victimized by service providers.
• In comparison to the general population, the rate of sexual assault is 10.7 times higher and the rate of robbery is 12.7 times higher (Sobsey & Doe, 1991; Sorenson, 2000).

• Up to 60% of those with developmental disability may have a genetic syndrome.
• ~40% have a diagnosis of epilepsy/seizure disorder.
• Predisposed to MH due to bullying, abuse, less access to education, financial security, stigma, etc., more likely to be observed for maladaptive behaviours…

What is Dual Diagnosis?

• CNSC-people who have a developmental disability and mental health issues and/or challenging behaviour.
• MOH/MCSS Adults with a Dual Diagnosis are those persons 18 years of age and older with both a developmental disability and mental health needs.

Some distinctions...

• Impairment
• Disability
• Handicap
• The goal is to prevent and/or minimize the impairments, disabilities and handicaps…

Definitions…

• Mentally Retarded
• Individuals with disability are a cultural group
• Preferences for language
Labels...

- Stigma, social expectations (or not), etc.
- How to make something good come from something perceived to be bad?
- Read both sides of the label...

What is...Developmental Disability?

“A particular state of functioning that begins in childhood and is characterized by limitation in both intelligence and adaptive skills.”

Evidence of limitations in adaptive functioning must occur in two or more of the following:

- communication, home living, community integration, health and safety, leisure, self care, social skills, self direction, functional academics, work.”

The Different Levels of Functioning

<table>
<thead>
<tr>
<th>Level</th>
<th>IQ</th>
<th>% of Occurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>50-55 to 70</td>
<td>85%</td>
</tr>
<tr>
<td>Moderate</td>
<td>35-40 to 50-55</td>
<td>10%</td>
</tr>
<tr>
<td>Severe</td>
<td>20-25 to 35-40</td>
<td>3-4%</td>
</tr>
<tr>
<td>Profound</td>
<td>below 20 or 25</td>
<td>1-2%</td>
</tr>
</tbody>
</table>

Adaptive skills...

- Communication
- Self-care
- Home living skills
- Social skills
- Community use
- Self-direction
- Health and safety
- Functional academics
- Leisure
- Work

Mental Health...

- 1 in 5 will have a MH at some point
- 37% with intellectual disability (id) will have MH problems
- Changes in sleep, eating, mood, behaviour...
- MH problems may manifest as somatic complaints, verbal complaints that do not directly indicate hallucinations, delusions, etc., aggression, sib...

Mental Health...

- Axis I-Clinical Disorders
  - Other Conditions that may be a focus of clinical attention
- Axis II-Personality Disorders, MR/ID
- Axis III-General Medical Condition
- Axis IV- Psychosocial and Environmental Problems
- Axis V- Global Assessment of Functioning
Mental Health...

• Axis I-severity of retardation or problem behaviour
• Axis II-associated medical conditions
• Axis III-Associated psychiatric conditions
• Axis IV-Global assessment of psychosocial disability
• Axis V-Associated abnormal psychosocial situations


Data Driven

• Data collection tools
  – FIDD
  – ABC
  – Scatterplot
• Operationalize
• Be consistent
• Share the information
• TRUST YOUR INSTINCTS...be an advocate!

Predisposition

• People with developmental disabilities have additional circumstances that predispose them to mental health disorders:
  – Biological factors
    • Epilepsy, sensory impairments, etc.
  – Psychological factors
    • Bullying, lower socioeconomic status, etc.
  – Social factors
    • Stigma, marginalization, etc.

Assessment via the Biopsychosocial Model (BPS)

<table>
<thead>
<tr>
<th>Factors</th>
<th>Areas of Assessment</th>
</tr>
</thead>
</table>
| BIO (medical) | • Medical  
|     |   • Syndromes  
|     |   • Psychiatric  
|     |   • Neurological state  
|     |   • Medication reactions  |
| PSYCHO (logical) | • Current psychological features  
|     |   • Skill deficits  |
| SOCIAL     | • Environmental  
|     |   • Interpersonal  
|     |   • Programmatic  |

Case Example...22q11.2

• 1/4000 births
• Under-recognized among those with ddx
• Notably in psychotic disorders
• This population may have less recognizable physical phenotypes
• Variability of presentation and symptomology
• Genetic test only became available in 1995
Z as seen through the BPS

- **Biological**
  - 22qDS
  - Epilepsy (history)
  - History of schizophrenia
  - Hypothyroidism
  - Movement disorder-nos
  - Sensory impairments
  - Skin breakdown
  - Neuroleptic malignancy syndrome

- **Psychological**
  - Problems with communication
  - Lost connection with religion/community
  - Dependency on caregivers
  - Boredom
  - Other

- **Social/environmental**
  - No friends
  - In hospital, limited privacy
  - Unpredictable staff approaches
  - Over/under-stimulated, minimal opportunities for community outings
  - Homeless
  - Distance from family

Are the individuals/family concerned?

Should there be concern?

Medical?

Mental Health Assessment Decision Tree

- Are the individuals/family concerned?
- Should there be concern?
- Medical?
- Problems with supports?
- Emotional problem?
- Psychiatric?

Barriers to assessment…

- Intellectual distortion*
- Psychosocial masking*
- Cognitive disintegration*
- Baseline exaggeration*

Barriers to assessment…

- Diagnostic overshadowing
- Medical overshadowing
- Behavioural overshadowing
- Cloak of competence

*Sovner & Des Noyers Hurley, 1989, as cited in Griffiths, Stavrakaki & Summers (Eds.), Dual Diagnosis, page 130.
Barriers...

• *Intellectual Distortion* refers to the diminished ability to think abstractly and communicate effectively.
• Emotional symptoms are difficult to elicit because of deficits in abstract thinking and in receptive and expressive language skills.

Barriers...

• *Psychosocial Masking* refers to the effects of the developmental disability upon the content of the psychiatric symptoms.
• Limited social experiences can influence the content of psychiatric symptoms (e.g., mania presenting as a belief that one can drive a car).

Barriers...

• *Cognitive Disintegration* refers to limited coping skills and cognitive impairment that tends to affect this group in becoming disorganized under stress.
• Decreased ability to tolerate stress, leading to anxiety-induced decompensation (sometimes misinterpreted as psychosis).

Barriers...

• *Baseline Exaggeration* describes how pre-existing behavioural challenges of a less significant level or maladaptive coping strategies may increase during periods of increased stress or psychiatric distress, and may be dismissed as possible symptoms of a psychiatric disorder because of their pre-existence.
• Increase in severity or frequency of chronic maladaptive behavior after onset of psychiatric illness.

Barriers...

• *Behavioural overshadowing* occurs when an increase in the intensity or frequency of the maladaptive behavior is attributed to ‘learned behaviour’ rather than a function and behavioural expression of an underlying medical or psychiatric disorder
• “She cries to get attention from staff”

Barriers...

• *Medical overshadowing;* present research indicates that physicians are less likely to order diagnostic tests to determine cause of symptoms for individuals with intellectual disabilities.
  “I don’t feel right…” (meaning; I have persistent feelings of vertigo and nausea), and being prescribed an antacid instead of differential diagnosis...
### Barriers…

- **Diagnostic overshadowing** occurs when all unusual and maladaptive behaviors are seen as a direct outcome of having a developmental disability
- “This woman is not psychiatrically unstable, you are a burnt out parent of a handicap. Both of you are angry and not coping…”

### Retrospect…

“False conclusions which have been reached are infinitely worse than blind impulse.”

- **Choices to:**
  - Educate
  - Admit when we are wrong, or don’t know
  - Seek consultation
  - Hear alternate hypotheses
  - Be creative
  - Be persuasive
  - Ask questions

### Decisions made…

“Life is just an endless chain of judgments, the more imperfect our judgment, the less perfect our success.”

- Possible different outcome for Z based on **one** different course of action
- Consensus guidelines for primary health care of adults with developmental disabilities (Sullivan et al, 2005) state;
  “If no cause is known, refer patient to a genetics centre for comprehensive etiologic assessment, including genetic testing, if indicated. Periodic reassessment might be necessary at intervals (e.g. 5 years).”

### The Multidisciplinary Team…

The team is the strongest chance to instill hope.

**MDT are most effective with:**
- Communication
- Continuity
- Roles
- Follow up

### How to mitigate problems in DDX…

- **Think biopsychosocial**
  - Beyond the current situation
  - Historical
  - Plan for the future
- **Learn the labels, recognize patterns**
  - Behavioural phenotypes
  - Literature (JABA, internet, community seminars, education)
  - Network

### Developing Resilience

**What?**
- Resilience protects from the negative impact of stressors

**How?**
- Set up the environment so that resilience is fostered along with increased coping skills, improved self-esteem, decreased anxiety and better mood regulation
Not is all as it seems...

- Comorbidity and overlap
  - Parsimony
  - Medication side effect or behaviour problem?
    - MEDS study
- Alternate theories
  - Epilepsy as psychiatric symptomolgy
  - Epilepsy as aggression
  - Epilepsy as a target behaviour

Medication Side Effects—Literature

- Looked at medication side effects in context of mental health disorders
- Best predictor of side effects (se) were challenging behaviours, especially aggression and to a lesser degree sib
- Used MEDS (measure of drug side effects)
- More severe se, more like psychiatric symptoms (impulse control, organic syndromes, mania) when compared with no/minimal se
- General trend toward an increase in pb in those experiencing severe side effects

Epilepsy and Seizures...

- 1-3% in general population
- ~30-50% with id
- Increases with severity of id
- ~30% will be drug refractory
- Triggers may be stress, changes in blood sugar, changes in medications, other environmental factors
- Seizures may occur as a one time event in response to febrile seizures, alcohol withdrawal, acute trauma, infection, metabolic illness
- Not all lead to convulsions, some manifest as aggression, psychiatric problems, etc....

Z now..

- Working on accessing resources, housing
- Referral to experts
- Increasing supports (hoping to improve resilience)
- Drug trials
- Ongoing assessment
- Education

In the end...

- Have hope, instill hope
- Watch for burnout
- Think Bio-Psychosocial
- Ask questions!
- Trust your instincts
- Be an advocate..

Thank you!
Case example for Dual Diagnosis ~ A Primer  
February 04, 2010

- 40 year old man
- Currently homeless, resides in hospital
- As a child Z was raised with one brother and sister
- Sister reports that Z was overly aggressive and struggled with social relationships
- He had some problems in school, never quite keeping up academically
- Z was held back once, completed grade 10, when mental health problems became salient around 17. He did not graduate from high school.
- As a child, medical problems included cornea transplants (around age 14-15), testicular surgery.
- Z achieved basic literacy skills, being able to read and write and perform simple math.
- Z had some sensory impairments, vision problems (identified early), mild hearing loss (identified during this admission to hospital) -always had problems with ears, frequent ear infections, etc.
- Seasonal allergies, probable lactose intolerance.
- 2 episodes of childhood pneumonia, prone to catching colds, flu’s.
- Had mumps at around 3 years old
- Z never had any major health problems until around the age of 35.
- Z developed borderline diabetes around age 30 and was required to monitor diet and to increase exercise. Had gained much weight (5’9, 220).
- At time of admission to hospital Z weighed around 180 lbs, there was dramatic weight loss, first lost 30 lbs, eventually down to 130 lbs (this is actually within healthy BMI)-not is all as it seems.
- Around the same time Z began to stutter off and on, which was not part of baseline.
- Around 2 years later, the stuttering did not resolve and some unilateral motor problems were observed and included dragging the right foot and apparent right sided weakness in the arms.
- 2 years ago became very ill, body temp of 92 degrees (hypothermic), resolved in general hospital about one week
- Got sick again, had a seizure, hospitalized again...unknown
- Neurological assessments at that time were inconclusive and the problems were described as “behavioural and attention seeking”
- Interestingly, the apparent motor symptoms seemed to come and go, which complicated the assessments process. This also perpetuated the assumption of problem behaviours.
- Historically, Z did have some incidents of problem behaviours, mainly in the form of aggression towards others.
- IN his 20’s Z came from out of province to hospital in Ontario
- Historical, seizures, neuroleptic malignancy syndrome
- Other brief incidents and admissions over the years, because of aggression
- Overdosed one Christmas due to mistake by pharmacy