NHS
Health Education England

Assessment of Mental Health Problems in Children and Adolescents with Intellectual Disability

Dr Dushyanthan Mahadevan
Dr Alison Dunkerley
Consultants Child and Adolescent Psychiatry

Health Education England

Epidemiology

- Emotional & behavioural disorders more common in children with a Learning Disability (Rutter et al, 1970)
- 36% with LD have diagnosable psychiatric disorder (Emerson & Hatton 2007)
  - 25.1% disruptive behaviour, 21.9% anxiety disorder, 4.4% mood disorder (Dekker & Koot 2003)

Health Education England

Discussion

- What is an Intellectual Disability?
- Is it the same as a Learning Disability?
- Or learning difficulties?

- What do you think are the key differences in assessing children (as opposed to adults) with ID and mental health problems?

Definition

- Intellectual disability (Rutter 2015)
  - A global and persistent reduction in cognitive abilities beginning early in development and associated with impairment in daily functioning including communication, social skills, personal independence and school/work functioning
  - Classification systems distinguish levels of severity based on measured IQ and degree of impairment in adaptive functioning

Health Education England

Objectives

- Assessment
- Introduction to management
- The value of the MDT and other agencies
- Limits of the evidence-base
- Principles and challenges of work in this area

Health Education England

Outline of presentation

- Role of professionals
- Principles of psychiatric assessment and the identification of aetiological factors
- Principles of psychiatric intervention
- Common co-morbid disorders in this population
- Challenging behaviour (NICE)
- Contexts of care

Health Education England

Discussion

- Which Professionals may play a role in mental health assessment
- What skills to they bring to the assessment?

Health Education England

Professionals

- Psychiatrist:
  - assessment, diagnosis, prescribing, physical health, MHA
- Psychologist: (Educational/Clinical)
  - neuropsychological testing, behavioural analysis, talking therapies
- Social Worker:
  - safeguarding, placement, activities, vulnerabilities, respite care
- Nurses/MHP:
  - (LD, Children's, Mental Health nurses) assess, case manage, behavioural interventions, lead groups, prescribe
- Occupational Therapist:
  - everyday functioning, skills and abilities, co-ordination, sensory profile
- Speech and Language Therapist:
  - assess communication skills, therapeutic work, ASD

Health Education England

History Taking

- Background information from other agencies
- Gauge developmental level of child
- Multiple informants
- Presenting complaint (precipitants?)
- Elicit details to support (or refute) hypotheses
- Family history: ID, epilepsy, psychiatric diagnoses
- Developmental history: birth, milestones
- Personal history: trauma, education, EHCP
- Risk & forensic history: self & others

Mental State Examination

- Child-friendly setting with toys, books (though consider safety)
- Enquire about emotionally neutral topics
- Sufficient time allowed, longer to understand
- Careful observation of child
  - Physical appearance
  - Abilities and activity levels
  - Communication and interaction with others

Health Education England

Investigations

- Physical examination
- Blood tests (screening and monitoring) where possible
- Genetic testing (microassays)
- Liaison with Paediatrics re: further tests

- Analysis of behaviour
- Multi-agency approaches in various settings
- Synthesis of information to inform care plans

Health Education England

Assessment of systems around the child

- Families
- Specialist education (Ed. Psych, school observations, school clinics)
- Children's Social Care
- Paediatric teams
- Third sector (respite, parent groups)

Standardised Assessments

- WISC-IV generates profile of performance
- ADI-R and ADOS
- Conners and Qb
  - Limits of validity in the ID population

- ABC (Aberrant Behaviour Checklist)
- DBC (Developmental Behaviour Checklist)

Aetiological Factors

- Demographic Factors
  - Male gender, low socio-economic status, living with one parent, living in an institution
- Other Psychosocial Factors
  - Self-esteem, ability to access activities, abuse, consistency of care, health of carers
- Biological Factors
  - Decreasing IQ, epilepsy, specific genetic syndrome, sensory impairment, communication difficulties

Health Education England

Specific Genetic Syndromes

- Prader-Willi: mood lability, sleep
- Williams: superficial language
- Fragile X: aggression, anxiety
- Rett Syndrome: hand movements, regression
- Down Syndrome: behaviour
- Smith-Magenis: sleep, behaviour
- Foetal Alcohol: executive function
- Velo-cardio-facial: psychosis

Health Education England

General Approaches

- Help families understand the diagnosis
- Understand the family's beliefs
- Support in coming to terms with disability, and then additional disorder
- Advocate for developmentally appropriate care and supervision
- Offer realistic hope
- Motivate others to change their approach
- Keep the child central in complex multi-agency care

Interventions

- Preventative
- Skills training
- Functional Communication Training
- Behavioural
  - Parent groups
  - Individual (based on functional analysis)
- Adapted psychotherapies (e.g. CBT)
- Autism-specific approaches (e.g. ABA)

Health Education England

Pharmacological Interventions

- Often don’t meet formal diagnostic criteria
- Used in combination with other approaches
- Specify treatment targets
- Monitor for adverse effects
- Watch for altered seizure thresholds
- Extrapolation from the generic evidence-base
- Off-licence prescribing common

Health Education England

Self-injurious Behaviour

- Functional analysis
- Behavioural, environmental and psychosocial interventions
- Treatment of comorbid conditions
- Treatment targets should be realistic
- Historically, antipsychotic drugs widely used
- SSRIs can be used, especially in context of anxiety/depression
- Naltrexone – limited evidence

Health Education England

ADHD

- Assess in context of developmental level
- Other causes of hyperactivity (sensory sensitivities or anxiety)
- Structured tools (interpret with caution)
- ID, ASD & ADHD often cluster
- Associations with behavioural disorders
- Range of evidence-based medications

Health Education England

ASD

- Common in ID affecting up to 50% of YP
- May be difficult to diagnose in severe ID
- Difficulties describing emotions/symptoms
- Assess in context of overall development
- Structured, multi-agency assessments
- Paediatric assessment may be indicated

Health Education England

Anxiety Disorders

- Anxiety disorders in 10-12%
- Can use tools (e.g. Spence) to track symptoms
- Environmental modification and cognitive/behavioural approaches useful
- Generally do not require psychopharmacology
- Role of SSRIs in supporting interventions (often Fluoxetine/Sertraline)

Health Education England

Affective Disorders

- Again subjective reporting of symptoms may be limited…
- Tools may support (diaries, MFQ)
- Analysis of collateral reports and risk
- Psychological and social approaches
- Medication can be beneficial (SSRIs in depression)
- Bipolar disorder under-recognised in ID (adult literature)

Tics

- Tics common in young people with ID
- Involuntary tics vs. stereotyped movements
- Associated with OCD & ADHD
- Diaries across multiple settings useful
- Interference with daily functioning, pain
- Antipsychotics most commonly used
- Clonidine can be useful with co-morbid ADHD

Health Education England

Schizophrenia & other Psychoses

- Auditory hallucinations, delusions, withdrawal
- Difficult to diagnose in severe ID
- Based on carer information & observation
- Important differential is ‘self-talk’ seen in ID
- Increase in soft neurological signs & epilepsy
- Good therapeutic responses to antipsychotics

Health Education England

Sleep Disorders

- Common in children with learning disabilities
- Sleep hygiene and diaries
- Melatonin preparations
- Rectification of sleep-wake cycle interference
- Duration of treatment is variable

Health Education England

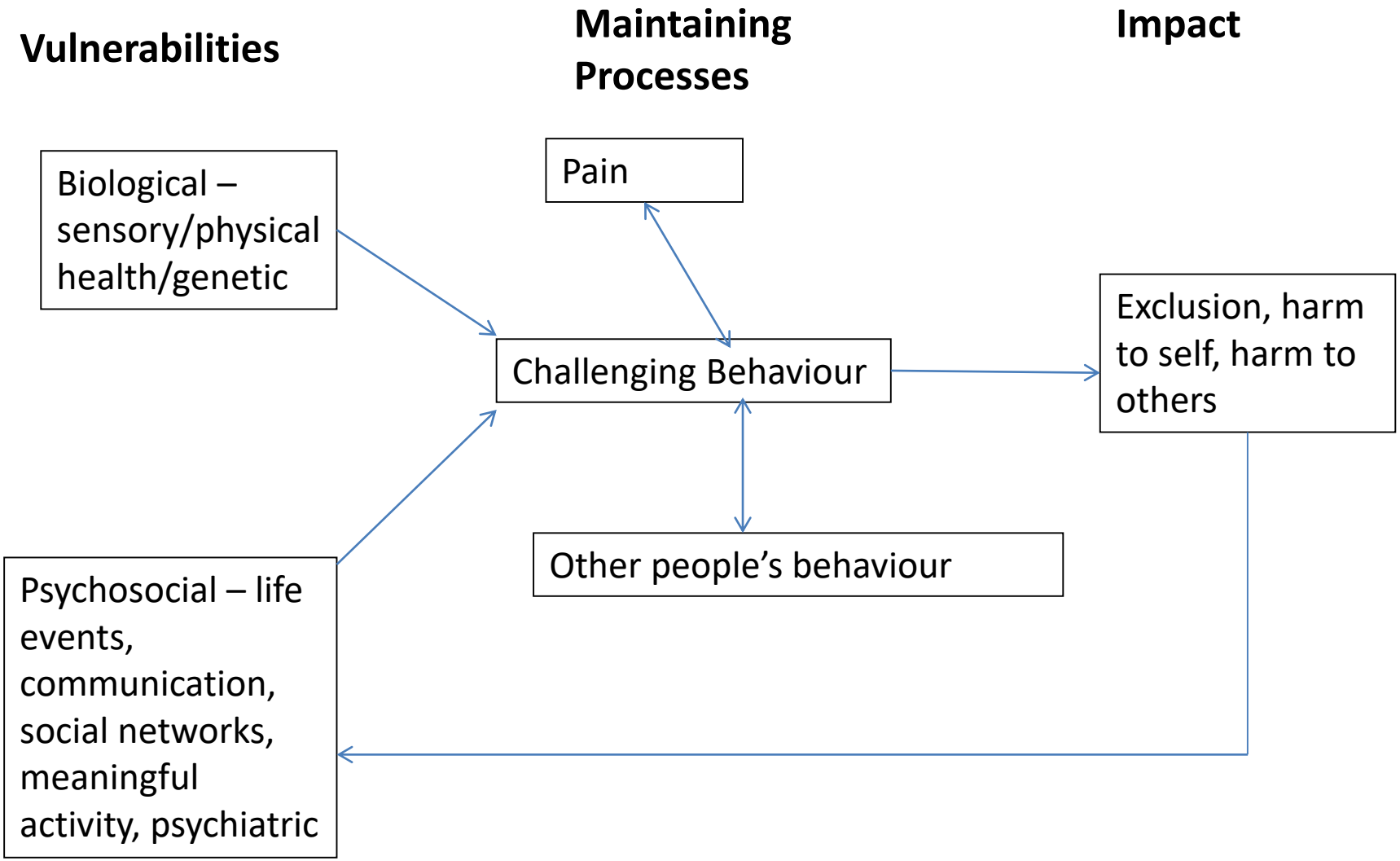
Challenging Behaviour (NICE)

- RCPsych definition (2007)
  - ‘Behaviour of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion.’
- Work with person & carers
- Understand function of behaviour
- Work in least restrictive way possible

Health Education England

General Principles of Care

- Clear focus on person, family & carers
- Interventions delivered in least restrictive setting
- Prompt & co-ordinated access to specialist services
- Staff training in strategies to reduce risk & manage behaviour
- Recognise impact on family/carers & consider support/groups etc.
- Strategies for early identification
- Annual physical health checks


Vulnerabilities
Maintaining Processes
Impact
Biological – sensory/physical health/genetic
Pain
Challenging Behaviour
Exclusion, harm to self, harm to others
Other people's behaviour
Psychosocial – life events, communication, social networks, meaningful activity, psychiatric

Health Education England

Assessment of Challenging Behaviour

- Person-centred with focus on outcomes & improving quality of life (resilience/resources)
- Regular review of self-harm/harm to others/ breakdown of family/abuse/escalation
- Functional assessment varied in complexity & intensity in line with behaviour that challenge
- Initial screening using MH assessment tools if MH problem might underlie behaviour

Health Education England

Interventions for Challenging Behaviour

- Parent training programmes for under 12s
- Functional assessment of behaviour
- Positive Behaviour Support
- Antipsychotic drugs only in combination with other interventions if
  - Psychological interventions don't produce change
  - Treatment for co-existing problems not reduced behaviour
  - Risk to person or others is severe
- Monitoring requirements
- Guidance on choosing medication (often Risperidone, Aripiprazole)

Health Education England

Reading: Challenging Behaviour

- Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenge NICE guidelines [NG11]
- Emerson E, Bromley J. The form and function of challenging behaviours. Journal of Intellectual Disability Research. 1995;39:388-98

Health Education England

Mental Health Act

- LD & no other form of mental disorder: may not be detained unless accompanied by abnormally aggressive or seriously irresponsible conduct
- Possible for ASD without mental disorder or behaviour (unlikely)
- LD defined as:- ‘a state of arrested or incomplete development of the mind which includes significant impairment of intelligence & social functioning’

Medicolegal issues

- Capacity to agree to admission?
- Parent can consent to admission, under 16yo
- Lack capacity, admitted in ‘best interests’ and not Deprivation of Liberty (use MHA under 18)
- Risk to patient or public
- History of non-compliance with treatment
- Consent/capacity fluctuating

Health Education England

Equality Act & Reasonable Adjustments

- Communication support
- Information in an accessible format
- Sufficient time for preparation before meeting
- Adapted treatment programmes
- Adapted therapeutic environment
- Risk assessment of personal safety
- Prioritised access/involvement of carers

Health Education England

In-patient Facilities

- Assessment/diagnosis/treatment
- Outreach work can shorten/eliminate admission
- Close liaison between in-patient/local teams
- Clear, integrated pathway of care incl. discharge
- Hard to achieve if geographically distant

Health Education England

Community Service Models

- Increased prevalence of mental disorder
- Requiring a different type of care
- Development of Specialist CAMHS for ID
- Inclusion agenda, all able to access facilities
- Person-centred planning & circles of support
- Gaps in provision
- Challenges in multi-agency working

Health Education England

Multi-agency Working

- Different professional cultures
- Inappropriate expectations
- Challenges in communication
- Learning from different perspectives
- Complementing each other's practice
- Joining up packages of care
- Seeking opportunities for collaboration

Health Education England

Policy Context

- Healthy Lives, Brighter Futures (DoH 2009)
- Winterbourne View (DoH 2012)
- Future in Mind (MHT 2015)
- Challenging Behaviour & LD (NICE 2015)
- Paving The Way (CBF 2015)
- Transforming Care (NHS England 2015)

Summary

- No effective treatments for the core cognitive deficits of ID
  - Focus on appropriate education and support for affected individuals and their families that maximize quality of life and community participation
  - Treatment planning should be multi-disciplinary and multi-agency
- The limited evidence base for treating psychiatric disorders in ID supports the use of similar interventions, although effect sizes may be diminished
  - Pharmacotherapy should involve lower starting doses, more gradual increases and careful monitoring, as people with ID are more sensitive to adverse effects

Summary

- Psychological interventions should utilize behavioural strategies, supported with visual materials and the involvement of parents/carers and other professionals such as teachers
- Family-wide support and respite care from voluntary groups and social services may be invaluable

Health Education England

MCQ's

- 1. People with intellectual disability have previously been classified as:
- A. Mentally retarded
- B. Learning disabled
- C. Sub-normals
- D. Imbeciles
- E. All of the above

Answer

Health Education England

- E

- 2. Intellectual disabilities are defined by which 3 core criteria?
- A. Lower intellectual ability
- B. Onset during childhood
- C. Onset before the age of 8
- D. Significant impairment of social or adaptive functioning
- E. IQ scores are not fixed throughout life

- A, B, D

- 3. Which of the following are generally accepted ranges (ICD-10, DSM-IV) for severity of ID (choose 4)?

- A. Mild (IQ 50-70)
- B. Mild (IQ 70-90)
- C. Moderate (IQ 50-70)
- D. Moderate (IQ 35-50)
- E. Severe (IQ 20-35)
- F. Severe (IQ 25-50)
- G. Profound (IQ below 25)
- H. Profound (IQ below 20)

- A, D, E, H

- 4. Which of the following 2 statements are true?
- A. Mild ID accounts for approximately 80% of children with ID.
- B. Approximately 50% of children with ID have moderate severity.
- C. Severe ID accounts for approximately 7% of the ID group.
- D. Profound ID affects 10% of children with ID.

- 4. A,C

- 5. The prevalence and incidence of ID varies according to gender, age, ethnicity and socioeconomic circumstances. Which statement is false?

- A. Studies generally report a female predominance in LD
- B. Increased maternal age is likely to lead to an increase in incidence of LD
- C. Ethnicity influences prevalence and incidence levels in ID due to the associated links with poverty, access to healthcare, and communications barriers amongst other factors
- D. Lower socioeconomic position is associated with higher prevalence of mild and moderate LD, but not severe LD.

- 5. A

- 6. Psychiatric illnesses frequently exist comorbidly with ID. Which of the following statements is false?
- A. Prevalence of psychiatric co-morbidity ranges from 30-70%
- B. There is often over diagnosis of co-morbid psychiatric conditions
- C. Practically all categories of mental illness are represented in the ID population
- D. Co-morbid psychiatric problems can vary and change with age

- 6. B

- 7. Match the following co-morbid problems with the age group they are most likely to present in:
- 1. Eating and sleep disorders — A. Adolescents
- 2. Self-injury — B. Very young children
- 3. ADHD — C. School age children

- 7. 1-B, 2-A, 3-C

- 8. Which one of the following psychiatric conditions is not generally associated with LD?
- A. Attention deficit hyperactivity disorder
- B. Mood disorders
- C. Anxiety disorders
- D. Psychotic illness
- E. Obsessive compulsive disorder
- F. Anorexia nervosa
- G. Autistic spectrum disorder

- 8. F

- 9. Behavioural analysis involves which ABC?
- A. Antecedents
- B. Awareness
- C. Boundaries
- D. Behaviour
- E. Consequences
- F. Circumstances

- 9. A,D,E

- 10. Which statement about management of ID is inaccurate?
- A. Medications are commonly under-prescribed when managing challenging behaviour associated with ID.
- B. Behavioural techniques are useful in managing ID
- C. Families provide the majority of support for most people with ID
- D. Social services provide the majority of support for people with ID outside of families

- 10. A